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Supreme Court, U.S.
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No. ———

In The
Supreme Court of the United States

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative
of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

SUSAN HEALY ZITTERMAN
Counsel of Record
KITCH DRUTCHAS WAGNER
VALITUTTI & SHERBROOK
ONE WOODWARD AVENUE
SUITE 2400
DETROIT, MI 48226
(313) 965-7905

Counsel for Petitioner

October 13, 2009

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), requires hospitals to "screen" any individual who "comes to the emergency department" and to "stabilize" an individual who is determined to have an "emergency medical condition." The Fourth and Ninth Circuits have held, and the Centers for Medicare and Medicaid Services ("CMS") by clarifying regulation in 2003 directed, that the obligation to stabilize does not apply to an individual who is admitted to the hospital in good faith for inpatient care. The Sixth Circuit in this matter has created a direct conflict with other circuits, and has ruled CMS's regulation invalid, by holding that EMTALA's stabilization requirement extends indefinitely to those admitted to a hospital for inpatient care.

The questions presented are:

1. Whether EMTALA's requirement that any individual who comes to a hospital's emergency department with an emergency medical condition be screened and stabilized should be expanded to continue indefinitely, after the individual has been admitted as an inpatient to the hospital for care or treatment?

2. Whether the CMS's regulation clarifying that EMTALA is inapplicable to hospital inpatients, 42 C.F.R. § 489.24(d)(2)(i), is valid, and applies retroactively?

LIST OF PARTIES AND CORPORATE DISCLOSURE STATEMENT

The parties to the proceeding in the Court of Appeals were Johnella Richmond Moses, Personal Representative of the Estate of Marie Moses-Irons, deceased, Providence Hospital and Medical Centers, Inc., and Paul Lessem, M.D. Dr. Lessem was a defendant as to whom summary judgment was affirmed by the Court of Appeals. Christopher Walter Howard was a third party defendant in the District Court (named by Providence acting as a third party plaintiff), but did not participate in proceedings before the Court of Appeals.

Providence Hospital and Medical Centers, Inc. is a private nonprofit corporation and does not have a parent corporation. There is no publicly held corporation owning more than 10% of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Providence Hospital and Medical Centers, Inc., respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The decision of the Sixth Circuit Court of Appeals is reported at *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 561 F.3d 573 (6th Cir. 2009), and is reproduced at Appendix, pp. 1a-33a. The order denying Petitioner's motion for rehearing en banc, with dissent, is reported at *Moses v. Providence Hosp. and Med. Ctrs., Inc.*, 573 F.3d 397 (6th Cir. 2009), and is reproduced at Appendix, pp. 34a-36a. The Order of the District Court for the Eastern District of Michigan granting defendants' motion for summary judgment entered July 30, 2008, is unreported, and is reproduced at Appendix, pp. 31a-33a.

JURISDICTION

This Court has jurisdiction to review the judgment of the U.S. Court of Appeals for the Sixth Circuit pursuant to 28 U.S.C. § 1254(1).

The judgment of the U.S. Court of Appeals for the Sixth Circuit sought to be reviewed was filed April 6, 2008. Petitioner's timely filed motion for rehearing en banc was denied by order filed on July 17, 2009. This petition is timely under 28 U.S.C. § 2101 and Supreme Court Rule 13.3, as it is being filed within 90 days of entry of the order denying rehearing of the opinion and judgment sought to be reviewed.

STATUTORY PROVISIONS INVOLVED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA") and 42 C.F.R. §§ 489.24(a)-(d)(2) are reproduced in the Appendix, pp. 37a-57a.

STATEMENT

This case raises a nationally important issue concerning the scope of the obligation of Medicare-participating hospitals under The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. Jurisdiction of the District Court was invoked under 42 U.S.C. §1395dd(d)(2)(A), which creates a civil action for damages by any individual who suffers a direct injury as a result of a violation of EMTALA, and under 28 U.S.C. § 1331 (general federal question).

A. EMTALA's Obligations And Penalties With Regard To A Hospital's Duty To Screen And Stabilize.

Congress enacted EMTALA, also known as the "Patient Anti-Dumping Act," in 1986 in response to concerns that hospital emergency rooms were refusing to treat patients with emergency conditions if the patient did not have medical insurance. See *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), quoting H.R. Rep. No. 241, 99th Cong., 1st Sess., Part I, at 27 (1985).

Under EMTALA, Medicare-participating hospitals must provide an "appropriate medical screening examination" to any individual who comes to the emergency department, to determine whether an "emergency medical condition" exists. 42 U.S.C. § 1395dd(a) (Appendix, pp. 37a.) An "emergency medical condition" is one of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing of the health of the individual in serious jeopardy, impairment or dysfunction. 42 U.S.C. § 1395dd(e)(1)(A). (Appendix, pp. 45a-46a.)

If an emergency medical condition is determined to exist, the hospital must either provide care to stabilize that condition, or transfer the individual to another medical facility if medically indicated. 42 U.S.C. § 1395dd(b)-(c). (Appendix, pp. 37a-41a.) "To stabilize" means "to assure, within reasonable medical probability, that no material deterioration of the [emergency medical] condition is likely to result from or occur during the transfer of the individual from a facility[.]" 42 U.S.C. § 1395dd(e)(3). "Transfer" is defined to include moving the individual to an outside facility, or discharging him. 42 U.S.C. § 1395dd(e)(4). (Appendix, pp. 46a-47a.)

EMTALA establishes penalties against hospitals and physicians who violate the requirements of the act of up to $50,000 per violation, and potential exclusion from the Medicare/Medicaid program. 42 U.S.C. § 1395dd(d)(1). The Act also creates a civil enforcement action for damages and appropriate equitable relief by any individual suffering personal harm, and by any medical facility suffering financial

loss. 42 U.S.C. § 1395dd(d)(2). (Appendix, pp. 41a-44a.)

B. Interpretation By The Fourth And Ninth Circuits, And By CMS Regulation, That EMTLA Does Not Apply To Individuals Admitted For Inpatient Care.

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), and *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), the Fourth and Ninth Circuits held that, consistent with EMTALA's limited purpose, its stabilization requirement does not apply once an individual who has come to the emergency department has been formally admitted to the hospital as an inpatient, rather than transferred or discharged. The Ninth Circuit in *Bryant*, *supra*, 1168, rejected as "dictum" the suggestion by the Sixth Circuit in *Thornton v. Southwest Detroit Hosp*, 895 F.2d 1131, 1135 (6th Cir. 1990), that EMTALA's stabilization requirement would extend indefinitely.

In 2002, Centers for Medicare and Medicaid Services (CMS), of the Department of Health and Human Services, the administrative agency charged with interpreting and implementing EMTALA, initially proposed rules extending EMTALA's stabilization requirement to inpatients. However, after extensive comments were received and considered, CMS withdrew that interpretation. In comments to its final rules promulgated in 2003 to clarify hospital responsibilities under the Act, CMS expressly endorsed the approach of the Courts in *Bryant* and *Bryan*, Federal Register, Vol. 68, No. 174, pp. 53244-5, and adopted 42 C.F.R. §489.24(a)(1)(ii)

and (d)(2), directing that a hospital's obligations under EMTALA end upon inpatient admission to the hospital. (Appendix, pp. 49a, 57a.)

C. Underlying Facts And Allegations In This Matter.

Respondent Johnella Richmond Moses, Personal Representative of the Estate of Marie Moses-Irons, deceased, in this matter seeks damages for an asserted violation of EMTALA in 2002, based upon the alleged premature discharge of Christopher Walter Howard, following 6 days of treatment as an inpatient at Petitioner Providence Hospital and Medical Center.

Marie Moses-Irons brought Mr. Howard to the emergency department of Providence Hospital in Southfield, Michigan, on December 13, 2002, because he was exhibiting signs of illness, including disorientation, hallucinations, and nausea. Mr. Howard was examined in the emergency department by an emergency medicine physician and a neurologist to determine why Mr. Howard was acting inappropriately. (Appendix, p. 3a.)

Based on that examination and testing, it was determined by hospital staff that longer term, inpatient care was necessary. Mr. Howard was admitted as an inpatient at Providence Hospital, and received inpatient medical and psychiatric care for the next 6 days. He was seen on a daily basis by Dr. Lessem, a psychiatrist, and was also seen by the neurologist, and an internal medicine specialist. (Appendix, pp. 3a-4a.)

Mr. Howard was discharged from the hospital on December 19, 2002, with a diagnosis of atypical psychosis, with delusional disorder. (Appendix, p. 5a.) At discharge, Mr. Howard was prescribed three types of medication. He was also given instructions to schedule office appointments for follow-up care with his primary care provider, and with the neurologist and psychiatrist who had treated him as a hospital inpatient. (Court of Appeals Joint Appendix, p. 179, Discharge Summary.)

Respondent's claim of a violation of EMTALA is directed to Mr. Howard's discharge on December 19. Respondent has alleged that at that time of Mr. Howard's discharge as an inpatient, hospital staff was aware that he still suffered from an unstabilized emergency medical condition, but discharged him when notified that his psychiatric care would not be covered by insurance. (Court of Appeals Joint Appendix, pp. 5, 8, first amended complaint.) Respondent alleges that as a result of the failure to stabilize Mr. Howard's psychiatric problem before he was discharged on December 19, 2002, Mr. Howard murdered his wife, Marie Moses-Irons, on December 29, 2002. (Appendix, p. 5a.)

In the District Court, defendants filed a motion for summary judgment on the ground that, *inter alia*, EMTALA does not apply after a patient has been admitted to a hospital and is discharged after 6 days of inpatient care. The District Court granted the motion, and respondent appealed. (Appendix, pp. 6a-7a.)

D. Court Of Appeals Decision.

The Sixth Circuit Court of Appeals in an opinion filed April 6, 2009, reversed summary judgment as to Providence Hospital and Medical Centers. The Court held, *inter alia*, that EMTALA forbids an individual's release (transfer or discharge) until the individual has been stabilized regardless of whether, or for how long, the individual was admitted from the emergency department to the hospital and treated as an inpatient. (Appendix, pp. 15a-20a.)[1] The Court held that the language of EMTALA requires treatment of the patient indefinitely until the emergency medical condition is stabilized, citing to a statement in *dicta* in its earlier decision in *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131, 1134 (6th Cir. 1990). (Appendix, pp. 16a-17a.)

The Court of Appeals further held that the administrative rule promulgated by CMS, that declares that a hospital's EMTALA obligations end upon admitting an individual as an inpatient in good faith, 42 C.F.R. § 489.24(d)(2), was invalid as inconsistent with the language of EMTALA.

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[1] The Court of Appeals also rejected alternative grounds advanced by defendants in support of the District Court's grant of summary judgment which are not at issue in this Petition. Those included arguments that there was no genuine issue of material fact that Mr. Howard did not have an unstabilized emergency condition at the time of his discharge, and that the estate of a nonpatient does not have standing to seek damages under EMTALA. (Appendix, pp. 10a-15a, 20a-26a.) The Court did affirm the dismissal of Dr. Lessem, holding that EMTALA does not create a cause of action for damages against an individual physician. (Appendix, pp. 26a-28a.)

(Appendix, pp. 18a-19a.) Alternatively, the Court concluded that the regulation would not in any event apply retroactively to Mr. Howard's care, which occurred before the regulation was implemented. (Appendix, pp. 19a-20a.)

Defendant Providence Hospital and Medical Centers timely filed a petition for rehearing en banc on April 20, 2009, which was denied by order of July 17, 2009. Judge Richard Griffin dissented, noting that the majority had "perpetuated a serious conflict" between circuits:

> By remaining loyal to the errant obiter dictum contained in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the majority has perpetuated a serious conflict between our circuit and the Ninth Circuit, *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Fourth Circuit, Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996), the federal regulations, 42 C.F.R. § 489.24(d)(2)(i), and the vast majority of lower court decisions. See generally *Preston v. Meriter Hosp., Inc.*, 747 N.W.2d 173 (Wis. Ct. App. 2008), petition for review denied, 749 N.W.2d 662 (Wis. 2008), and cases cited therein. [Appendix, pp. 34a-36a.]

Judge Griffin concluded:

> Our panel decision misconstrues EMTALA, making it a general federal medical malpractice statute, rather than an act limited to emergency room screening and stabilization. *Bryan*, 95 F.3d at 351. [Appendix, p. 36a.]

REASONS FOR GRANTING THE PETITION

The decision in this matter has created a direct conflict among three circuits, and thus uncertainty within the remaining circuits, as to the scope of Medicare participating hospitals' federally mandated obligation to provide care in an acute, hospital setting. The decision has declared invalid the clarifying regulation by CMS expressly intended to ensure uniform and consistent application of policy and to avoid misunderstanding of EMTALA's requirements by individuals, physicians, or hospital employees nationwide. The decision has extended federally mandated hospital care far beyond the clear intent of Congress to address a specific and limited concern--turning away patients from the emergency departments of acute care hospitals, or, by transfer, "dumping" patients in need of emergency care on other facilities.

The conflict in the circuits will have far-reaching legal, practical and financial effects on the nation's healthcare system. Hospital systems with a nationwide or multi-circuit presence will now be faced with conflicting obligations under federal law as to facilities located in the Fourth, Ninth and Sixth Circuits. Individual patients, physicians, hospital employees and administrators in the remaining circuits will face uncertainty as to what their rights or obligations will be under EMTALA. This decision will have significant ramifications for hospitals, expanding and creating uncertainty in liability for civil damages under EMTALA, as well as with regard to their daily operations in attempting to comply with the Sixth Circuit's mandate.

The Sixth Circuit's decision will have a direct adverse financial impact on the nation's already over-extended and under-reimbursed hospitals in mandating as a matter of federal law that hospitals provide acute, inpatient medical care indefinitely to those admitted with an emergency medical condition from the hospital emergency department. This obligation has been imposed regardless of the medical standard of practice or the futility of care, regardless of reimbursement, and regardless of the availability of care at other or less acute facilities that otherwise would be considered adequate by medical standards. The Court's decision will have a further adverse financial impact in creating near strict, federal tort liability and potential liability for civil fines when hospitals or physicians fail to provide care indefinitely, or transfer a patient to another, perhaps less acute, facility without the required certification.

The facts of this case well illustrate the implications of extending EMTALA to inpatient care, in questioning a physician's decision to discharge a patient after days of inpatient treatment, without regard to the reasonableness of the decision, or medical standards of care. As expressly concluded by CMS, the Medicare Conditions of Participation impose adequate safeguards for care, treatment and discharge of individuals admitted as inpatients. The Sixth Circuit's decision has turned EMTALA into a "super federal malpractice statute," superimposed upon and displacing state common law, directly contrary to what was intended by Congress.

The Sixth Circuit's decision in negating CMS regulations has decided an important federal question in a way that conflicts with the principles set forth by

this Court in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984), requiring deference to regulations of an administrative agency such as CMS. This has further magnified the lack of certainty created by the conflict between circuits.

Finally, in further holding that CMS's interpretive rules would have an impermissible retroactive effect if applied to care before their promulgation, the Court has also decided an important federal question in a way that conflicts with the principles set forth by this Court in *Smiley v. Citibank*, 517 U.S. 735, 744 n. 4, 116 S. Ct. 1730, 135 L. Ed. 2d 25 (1996).

I THIS CASE DIRECTLY PRESENTS A CONFLICT AMONG CIRCUITS OVER WHETHER EMTALA'S OBLIGATIONS APPLY BEYOND A HOSPITAL EMERGENCY DEPARTMENT TO INPATIENTS.

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), and *Bryan v. Rectors and Visitors of the Univ. of Virginia*, 95 F.3d 349 (4th Cir. 1996), the Courts directly held that EMTALA's requirements do not apply once an individual who has come to the emergency department has been admitted to the hospital for inpatient care, rather than transferred or discharged. This conclusion is consistent with EMTALA's language and purpose, and Congress's intent that it not become a federal malpractice statute.

In *Bryan*, the Fourth Circuit held that EMTALA did not provide a remedy where, after 12 days of inpatient treatment, the medical staff determined that no further efforts should be made to prevent the

patient's death (a "do not resuscitate" decision), and the patient died. As recognized the Court in *Bryan*, and by nearly every decision applying the Act, Congressional intent is clear that "EMTALA is a limited 'anti-dumping' statute, not a federal malpractice statute." *Bryan*, 95 F.3d 349, 352. "EMTALA is quite clear that it is not intended to preempt state tort law except where absolutely necessary. See 42 U.S.C. § 1395dd(f) (mandating that EMTALA preempt no state law requirement "except to the extent that the requirement directly conflicts with a requirement of [EMTALA]")." *Bryan*, 95 F.3d 349, 352.

The Fourth Court rejected the assertion that the stabilization requirement continues to apply even after the patient is admitted for inpatient care, based upon this Congressional intent, and the context in which the stabilization requirement appears in the statute, reasoning:

> [EMTALA] defines "to stabilize" as "to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual...." 42 U.S.C. § 1395dd(e)(3)(A). The stabilization requirement is thus defined entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system. It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment

> and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context. [*Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996).]

As also reasoned by the Court in *Bryan*, the interpretation of EMTALA urged by plaintiff there, and now imposed by the Sixth Circuit in this matter and all cases arising in this Circuit, requires a hospital to provide care ad infinitum:

> Under this interpretation, every presentation of an emergency patient to a hospital covered by EMTALA obligates the hospital to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up. Rather, without regard to professional standards of care or the standards embodied in the state law of medical malpractice, the hospital would have to provide treatment indefinitely - perhaps for years - according to a novel, federal standard of care derived from the statutory stabilization requirement. We do not find this reading of the statute plausible. [*Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996).]

The Court in *Bryan* noted that state tort law would apply to prevent and create a remedy for abandonment of inpatients prematurely discharged, a problem different than the national scandal being addressed by

Congress. The Court in *Bryan* concluded that the stabilization requirement only applied in the context of an imminent transfer or discharge of the patient from the emergency department:

> It seems manifest to us that the stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient to a hospital that could and would undertake that treatment. It cannot plausibly be interpreted to regulate medical and ethical decisions outside that narrow context. [*Bryan, supra*, 352.]

Further, as noted by CMS in later endorsing this position, hospitals would also still be obliged by Medicare Conditions of Participation ("CoPs") to provide quality care to inpatients:

> As a result of these court cases, and because we believe that existing hospital CoPs provide adequate, and in some cases superior protections to patients, we are interpreting hospital obligations under EMTALA as ending once the individuals are admitted to the hospital inpatient care. As an example of a case in which the hospital CoPs provide protection superior to that mandated by EMTALA, the discharge planning CoP in 42 CFR 482.43 includes specific procedural requirements that must be satisfied to show that there has been adequate consideration given to a patient's

> needs for post discharge care. EMTALA does not include such specific requirements. [Federal Register, Vol. 68, No. 174, p. 53245.]

In *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Ninth Court affirmed summary judgment dismissing an EMTALA claim where plaintiff was admitted through the emergency department as an inpatient, received care for 2 days, and was then transferred to another hospital where he died. The Ninth Circuit agreed with the *Bryan* Court's interpretation of "stabilize" as being limited to the context of actual transfer or discharge of an emergency room patient:

> Although the term "stabilize" appears to reach a patient's care after the patient is admitted to a hospital for treatment, the term is defined only in connection with the transfer of an emergency room patient. *Id.* § 1395dd(e)(3)(A) ("The term 'to stabilize' means . . . to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . ." (emphasis added)). Thus, the term "stabilize" was not intended to apply to those individuals who are admitted to a hospital for inpatient care. * * * [*Bryant, supra,* 1167.]

With virtual unanimity other federal district and state appellate courts have held that EMTALA does not apply after an individual is admitted from the emergency department as an inpatient. See *Preston v.*

Meriter Hosp., 747 N.W.2d 173, 307 Wis. 2d 704 (2009), *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. App. 1998), *Benitez-Rodriguez v. Hosp. Pavia Hato Rey, Inc.*, 588 F. Supp. 2d 210 (D.P.R. 2008), *Lopes v. Kapiolani Med. Ctr. for Women & Children*, 410 F. Supp. 2d 939, 948 (D. Haw. 2005), *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046, 1054 (E.D. Mo. 2005), *Dollard v. Allen*, 260 F.Supp. 2d 1127 (D. Wyo. 2003), *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 439 (E.D. Pa. 2004).

The Sixth Circuit's decision in this matter directly conflicts with the decisions of the Ninth and Fourth Circuits. The Court in this matter held:

> Contrary to Defendants' interpretation, EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit. . . . Thus, EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely. In the case of most emergency conditions, it is unreasonable to believe that such treatment could be provided by admitting the patient and then discharging him. [Appendix, p. 16a.]

The Sixth Circuit's rationale for its departure from other circuits, other state courts, and CMS, is in error in light of EMTALA's purpose and its language. The Court failed to address the rationale of the other circuits in concluding that EMTALA does not extend beyond the emergency department--that a patient who

becomes an inpatient is neither discharged nor transferred.

This Court addressed EMTALA in *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 250, 119 S. Ct. 685, 142 L.Ed. 2d 648 (1999), resolving the issue as to whether section 1395dd(b) requires proof that a hospital acted with an improper motive in failing to stabilize a patient. In *Roberts* the transfer at issue occurred after several weeks of inpatient hospital care, a fact not of significance to the issue decided by the Court there.

The Court in *Roberts* was not asked to consider the issue since addressed by the Fourth, Ninth, and now the Sixth, Circuits and CMS--whether EMTALA applies to inpatients. The Court should accept this matter to resolve this conflict.

II WHETHER CMS'S REGULATION DIRECTING THAT EMTALA DOES NOT APPLY TO HOSPITAL INPATIENTS IS INVALID AS MANIFESTLY CONTRARY TO THE STATUTE, IS AN IMPORTANT QUESTION OF FEDERAL LAW WHICH SHOULD BE SETTLED BY THIS COURT.

CMS has the congressional authority to promulgate rules and regulations interpreting and implementing Medicare-related statutes such as EMTALA. See generally 42 U.S.C. §§ 1302, 1395hh; 5 U.S.C. § 551, et seq. In 2003 CMS promulgated final rules, 42 C.F.R. Parts 413, 482, and 489, which it deemed necessary to clarify where and when EMTALA applies. CMS solicited public comments and took into account a range of objections to the proposed Regulations, providing a lengthy discussion responding to the

comments and its reasons for its interpretation in the Final Rule. Federal Register, Vol. 68, No. 174, pp. 53222-53264.

> These reiterating and clarifying changes are needed to ensure uniform and consistent application of policy and to avoid misunderstanding of EMTALA requirements by individuals, physicians, or hospital employees. [Federal Register, Vol. 68, No. 174, p. 53222.]

In 42 C.F.R. §489.24(a) and (d) (Appendix, pp. 49a, 57a), CMS has declared that the requirements of EMTALA do not apply after an individual seeking emergency medical care has been admitted in good faith to the hospital:

> (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual. [42 C.F.R. 489.24(d)(2)(i).]

In promulgating this rule, CMS expressly referenced with approval and endorsed as correct the holding of the Fourth and Ninth Circuits in *Bryan* and *Bryant*. As CMS reasoned:

> In reaching this result [that EMTALA does not apply to inpatients] the courts [in *Bryan* and *Bryant*] focused on the definition of "to stabilize" set out in the statute at section 1867(e)(3)(A) of

> the Act. In this definition, the Congress defined this concept by specifically linking the hospital's obligation to provide stabilizing treatment to individuals presenting with emergency medical conditions to the context in which the services are provided. * * *
>
> The courts gave great weight to the fact that hospitals have a discrete obligation to stabilize the condition of an individual when moving an individual out of the hospital to either another facility or to his or her home as part of the discharge process. Thus, should a hospital determine that it would be better to admit the individual as an inpatient, such a decision would not result in either a transfer or a discharge, and, consequently, the hospital would not have an obligation to stabilize under EMTALA. [Federal Register, Vol. 68, No. 174, p. 53244.]

The Court of Appeals here erred in declaring these regulations invalid as inconsistent with the statutory language, an error which will severely undermine CMS's goal of ensuring uniformity and predictability across the nation. The validity of CMS's construction of the EMTALA stabilization requirement is determined in accordance with the two-step process set forth by this Court in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 81 L.Ed. 2d 694 (1984). Contrary to the Court of Appeals' analysis here, the statute is at a minimum ambiguous, as best evidenced by conflicting decisions between the circuits as to its applicability to inpatients (with the vast majority endorsing the interpretation of CMS). Indeed, the statute is silent as to applicability

of EMTALA to the precise issue here--individuals who are not discharged or transferred upon identification of an emergency medical condition, but instead admitted as inpatients for further treatment.

Second, where as here, Congress has expressly delegated rule-making authority to the agency, 42 U.S.C. § 1302(a), the agency's interpretation is permissible and must be given controlling weight unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 843-44. CMS is a "highly expert agency" that "administers a large and complex regulatory scheme" in "cooperation with many other institutional actors." *Community Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 138 (2d Cir. 2002).

CMS's interpretation is not arbitrary or "manifestly" contrary to the statute. It is in line with the interpretation of two Courts of Appeals, and a multitude of federal district and state appellate courts. CMS's interpretation is the product of lawful rulemaking after the agency's consideration and extensive analysis of court decisions and many comments from the public and hospitals regarding the proposed rules, set forth in the Federal Register, Vol. 68, No. 174, pp. 53222-53264.

III THE COURT OF APPEALS' DECISION IN THE ALTERNATIVE THAT CMS'S REGULATION DOES NOT APPLY RETROACTIVELY CONFLICTS WITH RELEVANT DECISIONS OF THIS COURT.

The Court of Appeals decision establishes a standard by which CMS regulations would not be applied to care before their enactment which is clearly

inconsistent with fundamental principles established by this Court as to retroactivity. The "courts should apply the law in effect at the time they decide a case *unless* the law would have an impermissible retroactive effect as that concept is defined by the Supreme Court." *BellSouth Telecomms., Inc. v. Southeast Tel., Inc*, 462 F.3d 650, 657 (6th Cir. 2006). CMS's clarifying regulations would not have an impermissible retroactive effect.

The regulations were intended to clarify hospital obligations based upon case law existing at the time of the care at issue here, specifically *Bryan* and *Bryant*. These clarifying regulations were not inconsistent with any prior law or agency regulation; the statement in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), was, as recognized in the dissent to the denial or rehearing in this matter, "errant obiter dictum." (Appendix, p. 35a.) In *Smiley v. Citibank*, 517 U.S. 735, 744 n. 4, 116 S. Ct. 1730, 135 L.Ed. 2d 25 (1996), the Court characterized as "absurd" an argument that deferring to a clarifying regulation in a case involving antecedent transactions would make an administrative regulation impermissibly retroactive in violation of prior precedent:

> There might be substance to this point if the regulation replaced a prior agency interpretation--which, as we have discussed, it did not. Where, however, a court is addressing transactions that occurred at a time when there was no clear agency guidance, it would be absurd to ignore the agency's current authoritative pronouncement of what the statute means. [*Smiley v. Citibank*, 517 U.S. 735, 744 n. 4 (1996).]

So too here, petitioner submits, it would be "absurd" to ignore CMS's deliberate and authoritative pronouncement of what EMTALA means. The Sixth Circuit's determination that the regulations cannot be applied to Mr. Howard because they would have affected the extent of care that Mr. Howard could have expected is not warranted. Where two Circuit Courts of Appeals had directly addressed the issue consistent with CMS's later regulations, Mr. Howard could not have had any legitimate expectation of, or right to, potentially indefinite, lifetime hospital care.

The Court should grant certiorari to consider whether CMS's regulations are valid, and whether EMTALA applies to inpatients.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

KITCH DRUTCHAS WAGNER
VALITUTTI & SHERBROOK

By: SUSAN HEALY ZITTERMAN
Counsel for Petitioner
PROVIDENCE HOSPITAL AND
MEDICAL CENTER, INC.
One Woodward Avenue, Suite 2400
Detroit, MI 48226
(313) 965-7905

Dated: October 13, 2009

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 07-2111

[Filed April 6, 2009]

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES IRONS, deceased, *Plaintiff-Appellant*,

v.

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC. and PAUL LESSEM, *Defendants-Appellees*,

CHRISTOPHER WALTER HOWARD, *Third-Party Defendant*.

Appeal from the United States District Court for the Eastern District of Michigan at Detroit.
No. 04-74889—Anna Diggs Taylor, District Judge.

Argued: December 5, 2008

Decided and Filed: April 6, 2009

Before: CLAY and GIBBONS, Circuit Judges; STAMP, District Judge.*

COUNSEL

ARGUED: Mark Granzotto, MARK GRANZOTTO, P.C., Royal Oak, Michigan, for Appellant. Susan Healy Zitterman, KITCH, DRUTCHAS, WAGNER, DeNARDIS, VALITUTTI & SHERBROOK, Detroit, Michigan, for Appellee. **ON BRIEF:** Mark Granzotto, MARK GRANZOTTO, P.C., Royal Oak, Michigan, for Appellant. Susan Healy Zitterman, KITCH, DRUTCHAS, WAGNER, DeNARDIS, VALITUTTI & SHERBROOK, Detroit, Michigan, for Appellee.

OPINION

CLAY, Circuit Judge. Plaintiff Johnella Richmond Moses, as representative of the estate of Marie Moses-Irons ("Moses-Irons"), brings claims against Defendants Providence Hospital and Medical Centers, Inc. (the "hospital") and Paul Lessem ("Dr. Lessem") pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, and common law negligence. Plaintiff alleges that Defendants violated EMTALA by releasing Moses-Irons' husband from the hospital ten days before he murdered Moses-Irons. Plaintiff appeals the district court's decision to grant Defendants' motion for summary judgment and dismiss Plaintiff's claims. For the following reasons, we **REVERSE** the district

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* The Honorable Frederick P. Stamp, Jr., Senior United States District Judge for the Northern District of West Virginia, sitting by designation.

court and **REMAND** for further proceedings with respect to the hospital, but **AFFIRM** with respect to Dr. Lessem.

BACKGROUND

I. Factual Background

On December 13, 2002, Moses-Irons took Howard to the emergency room of Providence Hospital in Southfield, Michigan because Howard was exhibiting signs of illness. Howard's physical symptoms included severe headaches, muscle soreness, high blood pressure and vomiting. Howard was also experiencing slurred speech, disorientation, hallucinations and delusions. Moses-Irons reported these symptoms to the emergency room staff, and also informed them that Howard had "demonstrated threatening behavior, which made her fearful for her safety." (Joint Appendix ("J.A.") at 31-32.) The emergency room physicians decided to admit Howard to conduct more tests. Among the physicians who evaluated Howard during his stay at the hospital were Mark Silverman ("Dr. Silverman"), a neurologist; Dr. Lessem, a psychiatrist; and Djeneba Mitchell ("Dr. Mitchell"), an internist.

Dr. Silverman examined Howard on December 14, 2002. Dr. Silverman determined that Howard "was acting inappropriately" and "appeared to be somewhat obtunded," but had "no overt outward signs of trauma." (J.A. at 153.) In addition to informing Dr. Silverman of Howard's symptoms, Moses-Irons also told him that Howard had told her that he "had bought caskets." (J.A. at 150.) Dr. Silverman learned from Moses-Irons that Howard had recently tried to board

a plane with a hunting knife. Dr. Silverman ordered a magnetic resonance imaging exam, though it is unclear from the record whether the exam ever took place. Dr. Silverman also "felt that a psychiatric evaluation would be warranted," as well as a "lumbar puncture." (J.A. at 154, 158.) His notes from the evaluation indicate his belief that "an acute psychotic episode [must] be ruled out." (J.A. at 153, 158.)

Dr. Lessem examined Howard several times during Howard's stay at the hospital. On December 17, 2002, Dr. Lessem determined that Howard was not "medically stable from a psychiatric standpoint," and decided that Howard should be transferred to the hospital's psychiatric unit called "4 [E]ast" to "reassess him." (J.A. at 165.) According to Dr. Lessem, 4 East is intended for patients "who are expected to be hospitalized and stabilized and who are acutely mentally ill." (J.A. at 165.) Dr. Lessem felt Howard could be more closely observed at 4 East, and planned to conduct "reality testing" of Howard there to determine the extent of Howard's delusions. (J.A. at 168.) Dr. Lessem's order notes from December 17, 2002 state, "will accept [patient] to 4 [E]ast if [patient]'s insurance will accept criteria" and "please observe carefully for any indications of suicidal ideation or behavior." (J.A. at 172.) Under the heading "orders for 4 [E]ast," Dr. Lessem wrote, "suicide precautions." (J.A. at 173.) The notes also indicate that Dr. Lessem believed Howard had an "atypical psychosis" and "depression." (J.A. at 172.)

Howard was never transferred to the psychiatric unit, and instead was informed on December 18, 2002 that he would be released. A hospital clinical progress report signed by Dr. Mitchell that day stated that

"[patient] declines 4 [E]ast, wants to go home. His affect is brighter. No physical symptoms now. [Patient] wishes to go home, wife fears him. Denies any suicidality." (J.A. at 219.) Howard stated in a deposition that he never declined going to 4 East. In Howard's discharge summary form filled out on December 18, 2002, the hospital's "final diagnosis" of Howard, written by a resident, was that he had a "migraine headache" and an "atypical psychosis [with] delusional disorder." (J.A. at 178.) A report dated December 19, 2002, signed by Dr. Mitchell, indicated that Howard would be "[discharged] home today . . . cannot stay as he is medically stable and now does not need 4E." (J.A. at 89.) Howard was released on December 19, 2002, and on December 29, 2002, Howard murdered Moses-Irons.

On December 14, 2004, Plaintiff filed a federal suit against the hospital and Dr. Lessem, alleging a violation of EMTALA and various negligence claims. On January 5, 2005, Defendants filed a motion to dismiss the complaint, on the ground that EMTALA only provides a right of action for a plaintiff who sought treatment as a hospital's patient. On February 28, 2005, the district court denied Defendants' motion from the bench, stating, *inter alia*, that "the plain language of the statute does not preclude a lawsuit by the injured third party." (J.A. at 181.) Plaintiff filed an amended complaint on September 29, 2005. On January 6, 2006, Defendants filed a third-party complaint against Howard.

II. Motion for Summary Judgment

On May 14, 2007, Defendants filed a motion for summary judgment. In their brief supporting their

motion, Defendants raised two arguments: (1) that Plaintiff does not have standing to sue, because only the individual patient who seeks treatment at the hospital has standing under EMTALA; and (2) that EMTALA imposes no further obligation on a hospital once the hospital has admitted a person as an inpatient. Defendants' motion did not refer to any factual record, and they attached only the EMTALA statute and applicable regulations to their motion.

At oral argument before the district court on July 30, 2007, Defendants argued for the first time that the hospital physicians, after conducting the proper screening, did not diagnose Howard as having an emergency medical condition. At oral argument, Defendants referred in general terms to the testimony and documentation of the hospital physicians who attended to Howard to support this third argument, without producing the evidence they were referencing. Neither the December 18, 2002 progress report stating that Howard had no physical symptoms and denied "suicidality," nor the December 19, 2002 progress report in which Dr. Mitchell stated that Howard was stable, was attached to Defendants' summary judgment motion; however, both documents were attached to Defendants' response to a separate motion to compel discovery filed on April 13, 2007. During oral argument, Defendants also referred to letters from Howard's insurance company indicating that the insurance company did not deny coverage for Howard's treatment until January 2003, after Howard had been released; those letters were not submitted with Defendants' motion papers, nor are they included in the record on appeal.

Following oral argument, the district court granted Defendants' summary judgment motion from the bench, dismissing the EMTALA claim and choosing not to exercise jurisdiction over the negligence claims. In dismissing the EMTALA claim, the district court stated that summary judgment must be granted "regardless of the standing issue." (J.A. at 216.) The entirety of the district court's reasoning for granting summary judgment was as follows:

> First of all, the EMTALA statute was not designed or intended to establish guidelines for patient care or to provide a suit for medical negligence or malpractice. Under the clear and unambiguous language of the statute, the Plaintiff's claim must be dismissed. The hospital admitted Howard and did not turn him away, as was required by the Sixth Circuit in *Cleland [v. Bronson Health Care Group Inc.*, 917 F.2d 266 (6th Cir. 1990)]. The patient was undisputedly completely screened, as the statute requires, even if on the basis of a wrong diagnosis; and he was thereafter admitted to the Defendant hospital, and no emergency medical condition was recognized on the screening. So, for all of those reasons . . . the motion of the Defendants must be granted.

(J.A. at 216.) Plaintiff timely appealed.

On appeal, Plaintiff asserts that she did not receive fair notice that during oral argument Defendants would rely on evidence that the doctors believed Howard did not have an emergency medical condition. Had Plaintiff received proper notice, she asserts, she would have filed with her pleadings an expert report

by Harold J. Bursztajn ("Dr. Bursztajn"), a professor of psychiatry at Harvard Medical School, who concluded that Howard did have an emergency medical condition upon arriving at the hospital, and had not stabilized by the time he was discharged. Dr. Bursztajn based his conclusion on Dr. Lessem's own notes from December 17, 2002, in which Dr. Lessem had diagnosed Howard as having an atypical psychosis and possibly suicidal behavior. Dr. Bursztajn concluded that "the symptoms and mental state described by Dr. Lessem could not be resolved in one to two days, yet the decision to discharge Mr. Howard was made one day later." (J.A. at 68-69.) Dr. Bursztajn's expert report was served and filed on October 25, 2006, as part of Plaintiff's reply materials in connection with an earlier motion to compel a mental examination of Howard. Plaintiff includes this expert report in the record on appeal.

DISCUSSION

I. Standard of Review

This Court reviews a district court's grant of summary judgment *de novo*. *Monette v. Electronic Data Sys. Corp.*, 90 F.3d 1173, 1176 (6th Cir. 1996). Summary judgment is appropriate if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, "show that there is no genuine issue as to any material fact and that the movant is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). As the moving party, Defendants bear the burden of showing the absence of a genuine issue of material fact as to at least one essential element of Plaintiff's claim. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986). Plaintiff, as the non-moving party, must then present

sufficient evidence from which a jury could reasonably find for her. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). This Court must then determine "whether the evidence presents sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Id.* at 251-52. In making this determination, this Court must draw all reasonable inferences in favor of Plaintiff. *See Nat'l Enters., Inc. v. Smith*, 114 F.3d 561, 563 (6th Cir. 1997).

II. Overview of EMTALA

For all hospitals that participate in Medicare and have an "emergency department," EMTALA sets forth two requirements. First, for any individual who "comes to the emergency department" and requests treatment, the hospital must "provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists." 42 U.S.C. § 1395dd(a). Second, if "the hospital determines that the individual has an emergency medical condition, the hospital must provide either (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility[.]" § 1395dd(b). Thus, for any individual who seeks treatment in a hospital, the hospital must determine whether an "emergency medical condition" exists, and if the hospital believes such a condition exists, it must provide treatment to "stabilize" the patient. *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

The statute defines "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . [*inter alia*] placing the health of the individual . . . in serious jeopardy[.]" § 1395dd(e)(1)(A)(i). "To stabilize" a patient with such a condition means "to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility[.]" § 1395dd(e)(3)(A). "Transfer" is defined in the statute to include moving the patient to an outside facility or discharging him. § 1395dd(e)(4).

Including the argument made for the first time during oral argument before the district court, Defendants appear to have moved for summary judgment on three grounds: (1) Plaintiff lacks standing to sue under EMTALA; (2) EMTALA's requirements were satisfied when the hospital admitted Howard on December 13, 2002; and (3) because Howard was indisputably screened and diagnosed as not having an emergency medical condition, EMTALA did not apply. Because any one of these grounds would have been sufficient for the district court to grant summary judgment to the Defendants, we address each of them in turn.

III. Standing

In deciding Defendants' motion for summary judgment, the district court did not reach the issue of whether, as a non-patient, Plaintiff has standing under EMTALA to bring a claim, although it did deny Defendants' previous motion to dismiss on that

ground. Because Defendants prevailed below, this Court may consider affirming summary judgment based on Plaintiff's lack of standing. *See Dandridge v. Williams*, 397 U.S. 471, 475 n. 6 (1970) ("The prevailing party may, of course, assert in a reviewing court any ground in support of his judgment, whether or not that ground was relied upon or even considered by the trial court.").

Pursuant to EMTALA's civil enforcement provision, "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate." 42 U.S.C. § 1395dd(d)(2)(A). Neither this subsection, nor any other part of EMTALA, includes any mention of non-patients. Moreover, this Court is not aware of any federal appellate court that has addressed whether non-patients who allege harm as a result of a hospital's violation of EMTALA have standing to sue. Defendants cite two district court decisions from other circuits, which hold that the relatives of a patient who suffers harm cannot sue a hospital in their individual capacities for harm suffered by the patient. *See Zeigler v. Elmore Health Care Auth.*, 56 F. Supp. 2d 1324 (M.D.Ala. 1999); *Sastre v. Hosp. Doctors Center, Inc.*, 93 F. Supp. 2d 105 (D. Puerto Rico 2000). However, because the estate of the individual who suffered an actual personal injury brings the suit in this case, claiming personal harm as a direct result of the hospital's decision, those decisions are inapposite and of limited persuasive value.

"In the absence of an indication to the contrary, words in a statute are assumed to bear their 'ordinary, contemporary, common meaning.'" *Walters v. Metro. Educ. Enters., Inc.*, 519 U.S. 202, 207 (1997) (quoting *Pioneer Inv. Servs. Co. v. Brunswick Ass'ns Ltd. P'ship*, 507 U.S. 380, 388 (1993)). The plain language of the civil enforcement provision of EMTALA contains very broad language regarding who may bring a claim: "*any* individual who suffers personal harm as a direct result" of a hospital's EMTALA violation may sue. § 1395dd(d)(2)(A) (emphasis added). This language would seem to include Plaintiff, whose suit alleges that Moses-Irons' death was the direct result of the hospital's decision to release her husband before his psychiatric emergency medical condition had stabilized.

In arguing that only harmed *patients* may sue, Defendants contend that the phrase "any individual" in § 1395dd(d)(2)(A) must be read in the context of other parts of the statute. Because the medical screening requirement in § 1395dd(a) refers to an "individual" who "comes to the emergency department" and the stabilization requirement in § 1395dd(b) refers to an "individual" who "comes to a hospital," the term "any individual" in the civil enforcement provision should also be so limited. There are two problems with reading the statute this way. First, the medical screening requirement and the stabilization requirement do not refer to the same "individual"–the medical screening requirement of § 1395dd(a) only applies to individuals who come to an "emergency department," presumably a smaller subset of individuals than those "who come[] to a hospital" and are the subject of § 1395dd(b). This differing language indicates that Congress did not intend EMTALA's

entire statutory scheme to apply to the same "individual" in every part of the statute. Second, the fact that the statute expressly limits the individual to whom the hospital owes its EMTALA obligations in §§ 1395dd(a) and (b) further indicates that the breadth of the civil enforcement provision was no accident. "[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983); *see also Gozlon-Peretz v. United States*, 498 U.S. 395, 404-05 (1991). If Congress had intended to limit the right of action to any individual who "comes to a hospital" as a patient, it could have done so, just as it did in other parts of the statute. *See United States v. Parrett*, 530 F.3d 422 (6th Cir. 2008) ("Plain meaning is examined by looking at the language and design of the statute as a whole.").

Defendants also argue that EMTALA's legislative history supports their narrower construct of the civil enforcement provision. The original bill, reported out of the House Ways and Means Committee, extended the private right of action to "any person or entity that is adversely affected directly by a participating hospital's violation[.]" H.R. Rep. No. 99-241, pt. 1, at 132, *reprinted in* 1986 U.S.C.C.A.N. 579, 605. The bill was referred to the House Judiciary Committee, which amended the civil enforcement provision to a version essentially the same as its current form, changing "adversely affected" to "suffers harm as a direct result," and changing "person or entity" to "individual." H.R. Rep. No. 99-241, pt. 3 at 6, *reprinted in* 1986 U.S.C.C.A.N. 726, 728. The report from the House Judiciary Committee states that as a result of its

amendment to the bill, the only individual who can sue is the "individual patient who suffers harm as a direct result of hospital's failure to appropriately screen, stabilize, or properly transfer that patient." *Id.*

However, where a House committee's explanation of the meaning of a statute seems to differ from the statute's actual wording, this Court should not rely on that committee's statement as the exclusive explanation for the meaning of the statute. *See Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005) ("[J]udicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article I, may give unrepresentative committee members–or, worse yet, unelected staffers and lobbyists–both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text."). In this case, the parties have not pointed to any further legislative history, other than the one statement from the report of the House Judiciary Committee, as proof of Congress' intent with respect to the scope of the civil enforcement provision. We have also failed to uncover any substantive debate over the provision on either the House or Senate floors. As this Court has previously noted in examining EMTALA's legislative history, "[t]he only clear guidance from the legislative history is that Congress intended to prevent hospitals from dumping patients who suffered from an emergency medical condition because they lacked insurance to pay the medical bills." *Thornton*, 895 F.2d at 1134.

Regardless of the paucity of the legislative record on the standing issue, we believe that the civil enforcement provision, read in the context of the

statute as a whole, plainly does not limit its reach to the patients treated at the hospital. We therefore need not–and ought not–consult an isolated statement in a committee report. *See United States v. Choice*, 201 F.3d 837, 840 (6th Cir. 2000) ("The language of the statute is the starting point for interpretation, and it should also be the ending point if the plain meaning of that language is clear.").

We recognize that our interpretation of the civil enforcement provision may have consequences for hospitals that Congress may or may not have considered or intended. However, our duty is only to read the statute as it is written, as we have in our past analysis of EMTALA. In *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 269 (6th Cir. 1990), the defendants argued that because Congress sought to protect the rights of the indigent and uninsured in enacting EMTALA, only the indigent or uninsured should be allowed to sue under the act. This Court expressly rejected this narrow reading of the civil enforcement provision, stating that "[u]nfortunately for this theory, Congress wrote a statute that plainly has no such limitation on its coverage." *Id.* Similarly here, EMTALA's plain language belies Defendants' argument that Congress intended to deny non-patients the right to sue in every circumstance.

Thus, for the foregoing reasons, we conclude that Plaintiff has standing to sue pursuant to EMTALA.

IV. The Hospital's Obligations Upon Finding an Emergency Medical Condition

Defendants argue that, if Howard did have an emergency medical condition when he came to the

hospital, the hospital's decision to admit him for six days and perform further testing satisfied its obligations under EMTALA to treat so as to stabilize the patient. We disagree.

Contrary to Defendants' interpretation, EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit. The statute requires "such treatment as may be required to stabilize the medical condition," § 1395dd(b), and forbids the patient's release unless his condition has "been stabilized," § 1395dd(c)(1). A patient with an emergency medical condition is "stabilized" when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during" the patient's release from the hospital. § 1395dd(e)(3)(B). Thus, EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely. In the case of most emergency conditions, it is unreasonable to believe that such treatment could be provided by admitting the patient and then discharging him.

In *Thornton*, this Court examined whether EMTALA requires hospitals to do more for patients with emergency medical conditions than just admit them. 895 F.2d at 1134. In that case, it was undisputed that the patient initially had an emergency medical condition when the defendant hospital admitted her to the emergency room for a stroke; the issue was whether the hospital violated EMTALA by releasing her twenty-one days later from the hospital's regular inpatient care unit. *Id.* Although ultimately affirming summary judgment because the patient's

condition had stabilized prior to her release, this Court first rejected the hospital's argument that once it transferred the patient from the emergency room to inpatient care, its obligations under EMTALA were fulfilled:

> Congress sought to insure that patients with medical emergencies would receive emergency care. Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. *Emergency care must be given until the patient's emergency medical condition is stabilized.*

Id. at 1135 (emphasis added). Thus, the statute requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well. Accordingly, Defendants could not satisfy their EMTALA obligations merely by screening Howard and admitting him to conduct further testing.

To support their narrower reading of EMTALA's requirements, Defendants point to a rule promulgated by the Centers for Medicare and Medicaid Services ("CMS"), the agency responsible for implementing EMTALA, that effectively ends a hospital's EMTALA obligations upon admitting an individual as an inpatient. 42 C.F.R. § 489.24(d)(2)(i). According to the CMS regulation, "[i]f a hospital has screened an individual under paragraph (a) of this section and

found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual." *Id.*

Although "[a]n agency's construction of a statutory scheme that it is entrusted to administer is entitled to a degree of deference. . . . we must . . . 'reject administrative constructions which are contrary to clear congressional intent.'" *Gallagher v. Croghan Colonial Bank*, 89 F.3d 275, 277-78 (6th Cir. 1996) (quoting *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984)). The CMS rule appears contrary to EMTALA's plain language, which requires a hospital to "provide . . . for such further medical examination *and such treatment* as may be required to stabilize the medical condition[.]" § 1395dd(b)(1)(A) (emphasis added). Although "treatment" is undefined in the statute, it is nevertheless unambiguous, because it is unreasonable to believe that "treatment as may be required to stabilize" could mean simply admitting the patient and nothing further. Moreover, the statute requires the patient to be "stabilized" upon release; "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized . . . the hospital may not transfer the individual unless" the patient requests a transfer in writing or a physician or qualified medical person certifies that the risks of further treatment outweigh the benefits. § 1395dd(c)(1)(A). Therefore, a hospital may not release a patient with an emergency medical condition *without first determining that the patient has actually stabilized*, even if the hospital properly admitted the

patient. Such a requirement would be unnecessary if a hospital only needed to admit the patient in order to satisfy EMTALA. Because the CMS rule is contrary to the plain language of the statute, this Court does not afford it *Chevron* deference. *See Gallagher*, 89 F.3d at 278.

Even if the CMS regulation could somehow be deemed consistent with the statute, its promulgation in 2003, after Howard's stay in the hospital ended, would preclude this Court from applying it to this case. "As a general rule, a court 'must apply the law in effect at the time it renders its decision. Because '[r]etroactivity is not favored in the law,' however, courts should not construe 'congressional enactments and administrative rules . . . to have retroactive effect unless their language requires this result.'" *BellSouth Telecomms., Inc. v. Se. Tel., Inc.*, 462 F.3d 650, 657 (6th Cir. 2006) (quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 263-64 (1994)). To determine whether a regulation should be applied to events arising prior to the regulation's enactment, courts first inquire whether the regulation expressly reaches retroactively; if the regulation is silent on the issue, then the court asks "'whether applying the statute to the person objecting would have a retroactive consequence in the disfavored sense of affecting substantive rights, liabilities, or duties on the basis of conduct arising before its enactment.'" *Id.* at 658 (quoting *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (6th Cir. 2006)). If such rights are affected, then courts must apply a presumption against retroactivity. *Id.* Here, the CMS regulation is silent on retroactivity, and because the regulation would affect the extent of the care that Howard could have expected upon admission as an inpatient, the regulation "attaches

legal consequences to events completed before its enactment," *Landgraf*, 511 U.S. at 270. The CMS regulation therefore does not apply to this case, regardless of whether its interpretation of the statute is reasonable.

In short, the hospital was required under EMTALA not just to admit Howard into the inpatient care unit, but to *treat* him in order to stabilize him. Accordingly, Defendants are not entitled to summary judgment simply on the ground that the hospital admitted Howard as an inpatient and subjected him to several days of testing.

V. Existence of an Emergency Medical Condition

The district court's reasoning in granting summary judgment was partially predicated on its finding that the hospital conducted an appropriate screening, and that "no emergency medical condition was recognized on the screening." (J.A. at 216.) We believe that whether Howard had an emergency medical condition that the hospital recognized upon screening him is an issue of fact that the court should have left for a jury to decide.

As an initial matter, "before summary judgment may be granted against a party, Fed. R. Civ. P. 56(c) mandates that the party opposing summary judgment be afforded notice and a reasonable opportunity to respond to all issues to be considered by the court." *Routman v. Automatic Data Processing, Inc.*, 873 F.2d 970, 971 (6th Cir. 1989). "Rule 56(c) requires at a minimum that an adverse party be extended at least ten days notice before summary judgment may be entered." *Id.* "Noncompliance with the time provision

of the rule deprives the court of authority to grant summary judgment, unless . . . [*inter alia*] there has been no prejudice to the opposing party by the court's failure to comply with this provision of the rule." *Kistner v. Califano*, 579 F.2d 1004, 1006 (6th Cir. 1978) (citations omitted).

In this case, the district court granted summary judgment from the bench at the end of oral argument, and based its decision in part on the fact that the hospital never detected an emergency medical condition–a ground that Defendants had not raised prior to oral argument. Moreover, Defendants' briefs in support of their summary judgment motion did not include *any* supporting evidence whatsoever, as their written arguments were based purely on statutory interpretation; to the extent that the district court relied on any evidence at all with respect to this ground, such evidence came from exhibits Defendants attached to previous filings. Although there is no rule prohibiting the district court from considering previously submitted evidence–*see* Fed. R. Civ. P. 56(c) (allowing court to consider "the pleadings, the discovery and disclosure materials *on file*" in resolving a motion for summary judgment) (emphasis added)–it is still difficult to discern how Plaintiff could have received sufficient notice of this argument, or a reasonable opportunity to oppose it with evidence, without being advised that this issue would determine the district court's ruling on the motion.

With respect to prejudice, Plaintiff argues that had she known Defendants would raise the absence of an emergency medical condition at oral argument, she would have included Dr. Bursztajn's expert report in her opposition to Defendants' motion. Defendants had

notice of Dr. Bursztajn's report, because it was filed in connection with a previous motion to compel during discovery. We therefore will consider Dr. Bursztajn's report on appeal. In reviewing this report as well as the remainder of the evidence in the record, we find that issues of fact exist with respect to whether the hospital physicians actually believed Howard lacked an emergency medical condition.

An "emergency medical condition" is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . [*inter alia*] placing the health of the individual . . . in serious jeopardy[.]" § 1395dd(e)(1)(A)(i). The language in the statute does not appear to preclude classifying a psychiatric condition as an emergency medical condition, and "the health of the individual" could certainly include the individual's mental health. Moreover, we are not aware of any discussion of this issue in the legislative history. Without such guidance, we hold that a mental health emergency could qualify as an "emergency medical condition" under the plain language of the statute.

A. Howard's Condition Upon Arrival at the Hospital

At the time he came to the hospital, Howard was experiencing slurred speech, disorientation, hallucinations and delusions, and was making threatening statements, including telling his wife that he had "bought caskets." (J.A. at 150.) Howard's condition included physical symptoms such as severe headaches, muscle soreness, high blood pressure and

vomiting. Moreover, Dr. Bursztajn's report, based on a review of Howard's hospital records, concluded that Howard had an emergency medical condition upon arriving at the hospital. Thus, there is plenty of evidence in the record to create an issue of fact with respect to whether Howard's condition was a mental health emergency.

However, in order to trigger further EMTALA obligations, the hospital physicians must actually recognize that the patient has an emergency medical condition; if they do not believe an emergency medical condition exists because they wrongly diagnose the patient, EMTALA does not apply. *Roberts ex rel. Johnson v. Galen of Virginia, Inc.*, 325 F.3d 776, 786 (6th Cir. 2003).* Yet while actual knowledge is required, "any hospital employee or agent that has knowledge of a patient's emergency medical condition might potentially subject the hospital to liability under EMTALA." *Id.* at 788.

Howard was admitted to the hospital so that the hospital physicians could conduct further tests, including an MRI, a lumbar puncture and a psychiatric evaluation. On the first day of testing, Dr. Silverman's note that "an acute psychotic episode [must] be ruled out" indicated both the possible seriousness of Howard's condition and the need for further testing before a complete diagnosis could be made. (J.A. at 153, 158.) Dr. Lessem diagnosed

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* To the extent Plaintiff argues that the hospital's physicians were negligent in failing to recognize that Howard had an emergency medical condition, such an allegation is reserved for state malpractice law. *See, e.g., Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1166 (9th Cir. 2002).

Howard on December 17, 2002 as having "atypical psychosis," determined that Howard should be transferred to 4 East, and instructed 4 East doctors to take "suicide precautions." (J.A. at 173.) A legitimate possibility that the patient might commit suicide would appear to "place the health of the individual . . . in serious jeopardy," and could thus fall under the category of "emergency medical condition." *See* § 1395dd(e)(1)(A)(i). It is noteworthy that Dr. Lessem recommended Howard be transferred to 4 East, the unit for patients "who are acutely mentally ill." (J.A. at 160.) This evidence supports Plaintiff's claim that the hospital physicians believed Howard had an emergency medical condition upon his admission.

B. Howard's Condition Upon Discharge

Defendants argue further that, to the extent that Howard had an emergency medical condition at the time of his admission, the hospital physicians no longer believed that he had such a condition when they released him–i.e., that he was stable upon discharge. In *Cleland*, this Court, in affirming summary judgment for the defendant, explained why it was clear that the responsible doctors reasonably believed the patient had been stable upon discharge:

> To all appearances, the plaintiff's condition was stable. He was not in acute distress, neither the doctors nor the patient or his parents made the slightest indication that the condition was worsening in any way, or that it presented any risk that might become life-threatening, or that it would worsen markedly by the next day.

917 F.2d at 271.

Plaintiff has introduced evidence that challenges whether any of these signs of stability noted in *Cleland* existed with respect to Howard. First, the "final diagnosis" of Howard upon discharge of an "atypical psychosis [with] delusional disorder" was substantially the same as Dr. Lessem's diagnosis on December 17, 2002, which included "atypical psychosis." (J.A. at 169, 178.) Moreover, Dr. Bursztajn's report concludes that "the symptoms and mental state described by Dr. Lessem could not be resolved in one to two days, yet the decision to discharge Mr. Howard was made one day later." (J.A. at 68-69.) The doctors were aware on the day they released Howard that Howard's wife did not think he had improved, and in fact still "fear[ed] him." (J.A. at 219.) Finally, Dr. Lessem's note dated December 17, 2002, in which he writes "will accept [Howard] to 4 east if [Howard]'s insurance will accept criteria" (J.A. at 172), creates at the very least a credibility issue with respect to whether the hospital physicians actually believed that no emergency condition existed upon Howard's release.

To support their argument, Defendants cite Dr. Mitchell's progress note dated December 18, 2002, which states, "[Howard's] affect is brighter. No physical symptoms now. [He] wishes to go home, wife fears him. Denies any suicidality." (J.A. at 219.) Defendants also cite Dr. Mitchell's progress report dated December 19, 2002 stating that Howard "cannot stay as he is medically stable and now does not need 4 [East]." (J.A. at 89.) First, these notes do not refute Plaintiff's evidence that *Dr. Lessem* believed Howard was still unstable at the time of his release. But more importantly, while these notes may arguably provide a basis for a jury to find for Defendants, for the reasons discussed, Plaintiff's evidence still raises a

dispute of fact with respect to whether Howard had an emergency condition on the day of his release, and what the hospital's doctors believed when they released him.

Because issues of fact exist relating to Howard's medical condition–upon his initial screening as well as prior to his release–the district court erred in granting summary judgment on this ground.

VI. Plaintiff's EMTALA Claim Against Dr. Lessem

Plaintiff has brought suit against both the hospital and Dr. Lessem. EMTALA's provision authorizing private suits expressly allows claims "against the participating hospital," but does not refer to claims against individuals. 42 U.S.C. § 1395dd(d)(2)(A). Although the question of whether EMTALA allows a private right of action against an individual physician is one of first impression for this Court, other circuits to have considered the issue have held or opined that EMTALA does not authorize an action against an individual physician. *See Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 877-78 (4th Cir. 1992); *King v. Ahrens*, 16 F.3d 265, 271 (8th Cir. 1994); *Eberhardt v. City of L.A.*, 62 F.3d 1253, 1256-57 (9th Cir. 1995); *Delaney v. Cade*, 986 F.2d 387, 393-94 (10th Cir. 1993); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1040 n.1 (D.C. Cir. 1991) (*dicta*).

We agree with our sister circuits that EMTALA does not authorize a private right of action against individuals. "The question of the existence of a statutory cause of action is, of course, one of statutory construction." *Touche Ross & Co. v. Redington*, 442

U.S. 560, 568 (1979). It is possible that Congress meant to include individual physicians in the civil enforcement provision and simply neglected to do so; however, in comparing the civil enforcement provision with the government enforcement provision that precedes it, the omission of any reference to physicians in the civil enforcement provision appears intentional. The government enforcement provision authorizes the Department of Health and Human Services to commence its own actions against violators of EMTALA. 42 U.S.C. § 1395dd(d)(1). Unlike the civil enforcement provision, the provision authorizing government enforcement expressly states that "any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section . . . is subject to a civil penalty" and exclusion from further participation in government programs. § 1395dd(d)(1)(B). As previously discussed, "where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello*, 464 U.S. at 23. Congress clearly knew how to make individuals responsible under the statute, because it did so in the provision subjecting violators to federal enforcement. Given the contrast in these two consecutive subsections of the statute, Congress' omission of any reference to individuals in the civil enforcement provision must have been intentional.

Moreover, to the extent that the absence of such a reference arguably causes ambiguity with respect to

this issue, the legislative history reveals an intent to preclude private suits against individuals. According to the report of the House Judiciary Committee, the committee recommended amendments changing the civil enforcement provision to its current form in order to "clarif[y] that actions for damages may be brought only against the hospital which has violated the requirements of [the statute]." H.R. Rep. No. 99-241, pt. 1, at 132, *reprinted in* 1986 U.S.C.C.A.N. 579, 728. No other statement from Congress suggests any alternative reading of the provision. Because the statute contains no language plainly at odds with this stated purpose, we view the Judiciary Committee's report as further support for our conclusion that private plaintiffs may not sue individuals under EMTALA.

Thus, the district court's grant of summary judgment dismissing Plaintiff's claim against Dr. Lessem pursuant to EMTALA is affirmed.

CONCLUSION

For the reasons set forth above, with respect to Plaintiff's claims against the hospital, the judgment of the district court is **REVERSED** and **REMANDED** for further proceedings consistent with this opinion. With respect to Plaintiff's claim against Dr. Lessem pursuant to EMTALA, the district court's order granting summary judgment is **AFFIRMED**.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 07-2111

[Filed April 6, 2009]

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES IRONS, deceased, Plaintiff-Appellant,	)
v.	)
PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC. and PAUL LESSEM, Defendants-Appellees,	)
CHRISTOPHER WALTER HOWARD, Third-Party Defendant.	)

Before: CLAY and GIBBONS, Circuit Judges; STAMP, District Judge.

JUDGMENT

On Appeal from the United States District Court for the Eastern District of Michigan at Detroit.

THIS CAUSE was heard on the record from the district court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court with respect to plaintiff Johnella Richmond Moses' claims against

defendant Providence Hospital and Medical Centers, Inc. is REVERSED and REMANDED for further proceedings consistent with the opinion of this court. IT IS FURTHER ORDERED that the order of the district court granting summary judgment with respect to plaintiff Moses' claim against defendant Paul Lessem pursuant to EMTALA is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/
Leonard Green
Clerk

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No: 2:04CV74889
Hon. Anna Diggs Taylor
Magistrate Virginia M. Morgan

[Filed August 2, 2007]

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES IRONS, deceased,

Plaintiff,

-vs-

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC., a domestic non-profit corporation, and PAUL LESSEM,

Defendants and Third Party Plaintiffs,

-vs-

CHRISTOPHER WALTER HOWARD,

Third-Party Defendant.

JOSEPH C. SMITH P25480
JULIE A. GIBSON P34619
Attorneys for Plaintiff
23411 Northwestern Highway
Suite 1275
Southfield, MI 48034
(248) 353-0600

CHRISTOPHER WALTER HOWARD
In Pro Per- Third Party Defendant
Macomb Correctional Facility
34625 26 Mile Road
New Haven, MI 48048

RALPH F. VALITUTTI, JR. P26128
RYAN D. EWLES P64647
Attorneys for Defendants
10 South Main Street
Suite 307
Mt. Clemens, MI 48043
(586) 493-4431

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

At a session of said Court held in the U.S. District Courthouse, Eastern District of Michigan, City of Detroit, State of Michigan, on: JULY 30, 2007

PRESENT: ANNA DIGGS TAYLOR
U.S. DISTRICT COURT JUDGE

Upon filing of Defendants' Motion for Summary Judgment [D/E109], all parties having had the opportunity to respond, oral argument having been

heard, and the Court being fully advised in the premises:

IT IS HEREBY ORDERED that Defendants' Motion for Summary Judgment with respect to the Plaintiff's federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd, claims is GRANTED for the reasons set forth on the record of this Honorable Court.

IT IS FURTHER ORDERED that the Court will not retain jurisdiction over Plaintiff's state law claims.

DATED: August 2, 2007

/s/
ANNA DIGGS TAYLOR
UNITED STATES DISTRICT JUDGE

* * *

[Certificate of Service Omitted in Printing of this Appendix]

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 07-2111

[Filed July 17, 2009]

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES IRONS, deceased, *Plaintiff-Appellant*,

v.

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC. and PAUL LESSEM, *Defendants-Appellees*,

CHRISTOPHER WALTER HOWARD, *Third-Party Defendant*.

Before: CLAY and GIBBONS, Circuit Judges; STAMP, District Judge.*

ORDER

* The Honorable Frederick P. Stamp, Jr., Senior United States District Judge for the Northern District of West Virginia, sitting by designation.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and less than a majority of the judges having favored the suggestion, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

GRIFFIN, Circuit Judge, dissenting. I respectfully dissent from the denial of the petition for rehearing en banc. By remaining loyal to the errant obiter dictum contained in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the majority has perpetuated a serious conflict between our circuit and the Ninth Circuit, *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Fourth Circuit, *Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996), the federal regulations, 42 C.F.R. § 489.24(d)(2)(i), and the vast majority of lower court decisions. *See generally Preston v. Meriter Hosp., Inc.*, 747 N.W.2d 173 (Wis. Ct. App. 2008), petition for review denied, 749 N.W.2d 662 (Wis. 2008), and cases cited therein.

At issue is the construction of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395 dd. Contrary to the federal regulations and the weight of authority, a panel of this court in *Moses* held that federal law imposes a duty on hospitals that accept Medicare funding to adequately stabilize a patient after the hospital has satisfied its

emergency room obligations by either transferring the individual or admitting him for in-patient care. Our panel decision misconstrues EMTALA, making it a general federal medical malpractice statute, rather than an act limited to emergency room screening and stabilization. *Bryan*, 95 F.3d at 351.

For these reasons, I would grant rehearing en banc and therefore respectfully dissent.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green

Clerk

APPENDIX D

42 U.S.C. § 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement.

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor.

(1) In general.

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either–

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment.

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer.

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The

hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized.

(1) Rule.

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless–

(A)

(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an

individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer.

An appropriate transfer to a medical facility is a transfer–

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility–

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement.

(1) Civil monetary penalties.

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b))

shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who–

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with

respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement.

(A) Personal harm.

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility.

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions.

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations.

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation.

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions.

In this section:

(1) The term "emergency medical condition" means–

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in–

(i) placing the health of the individual (or, with respect to a pregnant woman, the

health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions–

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title].

(3)

(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who

(A) has been declared dead, or

(B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption.

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination.

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment.

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections.

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

APPENDIX E

42 C.F.R. § 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must –

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2) *Nonapplicability of provisions of this section.* Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan do not apply to a hospital with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.

(b) *Definitions.* As used in this subpart –

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual –

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if –

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the

ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a non-hospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means –

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in –

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions –

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in § 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means –

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in § 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions.* – (1) *General.* Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare

benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either –

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Exception: Application to inpatients.* (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

* * *

148 (3)

No. 09-438

Supreme Court, U.S.
FILED
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In The
Supreme Court of the United States

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative
of the Estate of Marie Moses-Irons, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF IN OPPOSITION

JULIE A. GIBSON
SMITH & GIBSON, P.C.
28411 NORTHWESTERN HWY.
SUITE 1275
SOUTHFIELD, MI 48034
(248) 353-0600

MARK GRANZOTTO
Counsel of Record
MARK GRANZOTTO, P.C.
225 SOUTH TROY STREET
SUITE 120
ROYAL OAK, MI 48067
(248) 546-4649

Counsel for Respondent

December 16, 2009

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTIONS PRESENTED

Whether the facts of this case and respondent's theory of recovery under the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd, serve to distinguish the Sixth Circuit's ruling in this case from the Ninth Circuit's decision in *Bryant v. Adventist Health Systems*, 289 F.3d 1162 (9th Cir. 2002), and the Fourth Circuit's decision in *Bryan v. Rectors and Visitors of the University of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996)?

Whether the Sixth Circuit correctly applied the well established legal doctrine that a court must reject administrative constructions of a statute which conflict with congressional intent?

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STATEMENT OF THE CASE

On December 13, 2002, Marie Moses-Irons took her husband, Christopher Walter Howard, to the emergency department at Providence Hospital, after Mr. Howard began exhibiting signs of acute mental illness. Ms. Moses-Irons advised members of Providence Hospital's staff that her husband was speaking inappropriately, had slurred speech and was hallucinating. She also reported to the hospital's staff that Mr. Howard demonstrated threatening behavior toward her, and that she was fearful for her own safety and for that of the couples' two children. While at Providence Hospital on December 13, 2002, Mr. Howard called his wife over to his bed and said to her, "Tell your mother I have coffins for the children." Ms. Moses-Irons reported this statement to the Providence Hospital's staff treating Mr. Howard.

On December 13, 2002, after Mr. Howard was admitted to Providence Hospital, he was examined by a neurologist, Dr. Mark Silverman. Dr. Silverman concluded that Mr. Howard required a psychiatric evaluation after finding him "babbling about strange things. He apparently told his mother-in-law he had bought caskets . . ."

Dr. Paul Lessem, a psychiatrist, examined Mr. Howard on December 14, 2002. At the time of his examination, Dr. Lessem was aware that Mr. Howard had made threats of physical harm against his wife and other family members. Dr. Lessem concluded that Mr. Howard had an emergency medical condition and that he needed a complete medical work-up and further observation.

Mr. Howard's psychiatric condition deteriorated while a patient at Providence Hospital. Ms. Moses-Irons became increasingly fearful of her husband's bizarre behavior during his hospitalization. Mr. Howard asked his wife while he was in Providence Hospital: "Have these hands murdered someone? Have I killed someone?"

Dr. Lessem saw Mr. Howard again on December 17, 2002. Dr. Lessem recorded that Mr. Howard exhibited bewilderment and depression. Dr. Lessem also noted that, because of Mr. Howard's behavior over the prior few days, Ms. Moses-Irons was fearful of taking him home.

As of December 17, 2002, Dr. Lessem recognized that Mr. Howard required additional treatment to stabilize his psychiatric condition. It was decided that Mr. Howard would be admitted to Providence Hospital's secured psychiatric unit, 4 East, where Mr. Howard would be subject to twenty-four hour monitoring on a "lock down" unit. According to Dr. Lessem, 4 East was intended for patients "who are expected to be hospitalized and stabilized and who are acutely mentally ill." But, Mr. Howard's transfer to 4 East was contingent on Mr. Howard's insurance covering the cost of the treatment. This contingency was recorded in an order written by Dr. Lessem on December 17, 2002: "Will accept [patient] to 4 [E]ast if [patient's] insurance will accept criteria. Atypical psychosis with somatization and depression. Please observe carefully for any indications of suicidal ideation or behavior."

A member of the hospital's staff contacted Mr. Howard's insurance carrier to determine if his health

insurance would cover the psychiatric treatment which he was about to undergo. Mr. Howard's insurer advised Providence Hospital that there would be no coverage for any such treatment, and that the only treatment which his insurance would cover would be the first two days of his hospitalization, December 13 and 14, 2002. The proposed transfer of Mr. Howard to the hospital's psychiatric unit did not occur.

Instead, the following day, December 18, 2002, Mr. Howard was informed that he would be released. In a discharge summary form filled out on December 18, 2002, Mr. Howard's "final diagnosis" was that he had a "migraine headache" and "atypical psychosis [with] delusional disorder."

On December 19, 2002, Mr. Howard was discharged from Providence Hospital. At the time the decision was made to discharge Mr. Howard, Dr. Lessem was aware that Mrs. Moses-Irons' feared for her own safety and for that of her family. Dr. Lessem recommended that when Mr. Howard was released, Ms. Moses-Irons should arrange to have him stay in a hotel rather than in the couple's home.

Based on Dr. Lessem's recommendation, Ms. Moses-Irons made arrangements for Mr. Howard to stay in a hotel after his December 19, 2002 discharge. She also had the locks on her home changed because of her fear of what Mr. Howard might do in his existing mental condition.

On December 29, 2002, ten days after he was released from Providence Hospital, Mr. Howard murdered Marie Moses-Irons.

Johnella Richmond Moses, the Personal Representative of the Estate of Marie Moses-Irons, filed this action on December 14, 2004. In her Complaint, Mrs. Moses alleged claims under a federal statute, the Emergency Medical Treatment And Active Labor Act, 42 U.S.C. §1395dd (EMTALA), as well as claims under Michigan common law.

On May 14, 2007, Providence Hospital filed a motion for summary judgment seeking dismissal of Mrs. Moses' EMTALA claim. Among the arguments that Providence Hospital raised in its motion was that EMTALA only applied to the transfer of a patient from a hospital's emergency department. Since Mr. Howard was admitted as a patient for a period of days before his December 19, 2002 discharge, Providence Hospital maintained that his discharge could not be the subject of an action under the EMTALA.

The district court granted summary judgment on the EMTALA claim. In reaching this result, the district court did not address Providence Hospital's argument that its admission of Mr. Howard discharged all responsibility that it may have had under EMTALA.

Mrs. Moses appealed the district court's summary judgment ruling to the United States Court of Appeals for the Sixth Circuit. In that Court, Providence Hospital again asserted as an alternative basis for the dismissal of the EMTALA claim its argument that this statute only provides a remedy to a patient who is released in an unstable condition from a hospital's emergency department.

In an opinion issued on April 6, 2009, the Sixth Circuit reversed the district court's grant of summary judgment on Mrs. Moses' EMTALA claim. The Sixth Circuit, relying on its earlier decision in *Thornton v. Southwest Detroit Hospital,* 895 F.2d 1131 (6th Cir. 1990), ruled that Mrs. Moses had a viable claim under EMTALA because issues of fact remained on whether Mr. Howard had an emergency medical condition which had yet to be stabilized at the time of his December 19, 2002 discharge from Providence Hospital. Pet. App. 15a-26a.

REASONS FOR DENYING THE WRIT

Providence Hospital contends that EMTALA's "anti-dumping" prohibition begins at a hospital's emergency department and ends as soon as a patient is admitted to the hospital. If correct, petitioner's argument would mean that a hospital could "circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient." *Thornton*, 895 F.2d at 1135.

I. THE CLAIMED CONFLICT WITH DECISIONS OF THE FOURTH AND NINTH CIRCUIT

Central to petitioner's argument is a claimed conflict between the decision of the Sixth Circuit in this case and the rulings of the Fourth and Ninth Circuits in *Bryan v. Rectors and Visitors of the University of Virginia*, 95 F.3d 349 (4th Cir. 1996) and *Bryant v. Adventist Health Systems*, 289 F.3d 1162 (9th Cir. 2002). Neither of these cases reaches a conclusion which is necessarily in conflict with the decision in this case.

In *Bryan*, the Fourth Circuit considered an EMTALA claim brought on behalf of a woman who was admitted to a hospital for respiratory distress. The hospital had provided stabilizing treatment for a period of days when members of its staff entered a "do not resuscitate" order. Plaintiff alleged that this order was contrary to the wishes of the patient's family. When plaintiff's decedent died of a heart attack eight days after the "do not resuscitate" order was put into effect, her estate sued under EMTALA action.

The plaintiff in *Bryan* alleged the existence of a claim under 42 U.S.C. §1395dd(b), the subsection of EMTALA which provides:

> (b) Necessary stabilizing treatment for emergency medical conditions and labor
>
> (1) In general
>
> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either --
>
> **(A)** within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
>
> **(B)** for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

Based on EMTALA's definition of the phrase "to stabilize" contained in 42 U.S.C. §1395dd(e)(3)(A), the Fourth Circuit held in *Bryan* that the stabilization requirement of 42 U.S.C. §1395dd(b) "is defined entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system." *Bryan*, 95 F.3d at 352.

In *Bryan*, the Fourth Circuit considered a case in which there was no transfer as that term is defined in EMTALA. *See* 42 U.S.C. §1395dd(e)(4). On this basis, the decision in *Bryan* must be distinguished from this case. Here, Mr. Howard's December 19, 2002 discharge from Providence Hospital meets EMTALA's definition of a discharge. *Id.*

In the *Bryant* case, the plaintiff's decedent went to a hospital emergency department on January 24, 1997. During that visit a chest x-ray was misinterpreted and the patient was released. Later that day, a doctor detected the error in the reading of the x-ray and an employee of the hospital called the patient's parents, instructing them to return to the hospital. Once the patient returned, he was admitted to the hospital. On January 28, 1997, the patient was transferred to another hospital where he underwent emergency surgery.

The patient died suddenly slightly over one month after the surgery was performed and plaintiffs instituted an action under EMTALA against the hospital that treated their decedent between January 24 and January 28. In that EMTALA claim, plaintiffs alleged that this federal act was violated both during the January 24, 1997 emergency department visit and the three day hospitalization that began the following

day. The plaintiff in *Bryant* did not contend that the emergency transfer which occurred on January 28, 1997 violated EMTALA. *Bryant*, 289 F.3d at 1164.

Thus, like the Fourth Circuit's ruling in *Bryan*, the Ninth Circuit's decision in *Bryant* did not involve the transfer provisions of EMTALA. Moreover, the *Bryant* Court did not adopt the bright line rule that petitioner urges this Court to adopt. *Bryant* did not hold that all liability under EMTALA is automatically eliminated upon admission to a hospital. Instead, the Ninth Circuit held that EMTALA's "stabilization requirement *normally* ends when a patient is admitted for inpatient care." 289 F.3d at 1167 (emphasis added). The *Bryant* Court posited a potential exception to the rule that all responsibility under EMTALA is discharged by admission to a hospital in those situations in which a hospital admits a patient with no intention of providing treatment. *Id.* at 1169.

While the exception discussed in *Bryant* has no application to this case, the mere fact that that the Ninth Circuit was compelled to recognize that the policy objectives of EMTALA might call for liability even when a patent is admitted to the hospital is of significance here. Petitioner stresses that EMTALA is an "anti-dumping" statute, precluding hospitals from refusing treatment to those who are unable to pay for it. Despite the fact that Mr. Howard was admitted to Providence Hospital on December 13, 2002, his transfer six days later directly implicated EMTALA's anti-dumping provisions.

On December 18, 2002, Mr. Howard's psychiatric problems were considered so severe that his treating psychiatrist, Dr. Lessem, wanted him admitted to the

hospital's secured psychiatric unit, designed to house the "acutely mentally ill." Pet. App. 4a. Dr. Lessem wrote a note indicating that Mr. Howard would be transferred to this secured psychiatric unit "if [patient's] insurance will accept criteria." *Id.*

When it was discovered that Mr. Howard's insurer would pay only for the first two days of inpatient psychiatric care, the plan to place Mr. Howard in the secured psychiatric unit was abandoned. In addition, the following day the decision was made to release Mr. Howard. Thus, in the space of a single day, Mr. Howard went from a patient who was recommended for transfer to a unit of the hospital for the "acutely mentally ill," to being advised that he was to be released from the hospital altogether.

This is a case which directly implicates the anti-dumping policy behind EMTALA. In this case, there is evidence establishing that Mr. Howard's inpatient treatment was terminated after it was discovered that his insurance would not pay any part of that treatment. Where, as here, plaintiff can demonstrate that the decision to transfer Mr. Howard was motivated by payment concerns which were addressed in EMTALA, that statute should provide a remedy.

II. THE CENTERS FOR MEDICARE AND MEDICAID SERVICES' REGULATIONS

Petitioner argues that the Court should review the Sixth Circuit's April 6, 2009 decision because of its treatment of the 2003 regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). The Sixth Circuit recognized that an agency's construction of the statutory scheme it administers is

entitled to a degree of deference. Pet. App. 18a. But, it held that it must "reject administrative constructions which are contrary to clear congressional intent." *Id.* There is nothing groundbreaking or controversial in the Sixth Circuit's formulation of the principles governing the relationship between courts and regulations promulgated by administrative agencies. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843, n. 9 (1984).

Nor did the Sixth Circuit err in its conclusion that the CMS regulation specifying that a hospital discharges all potential liability under EMTALA by admitting a patient is at odds with congressional intent as expressed in the text of that statute. It is noteworthy that when CMS first spoke on this subject in 2002, it proposed rules extending EMTALA's stabilization requirements to patients who were admitted to the hospital. In 2003, CMS reversed course and issued the regulation on which petitioner now relies, 42 C.F.R. §489.24(d)(2)(i).

CMS's vacillation on this issue serves to highlight the fact that the language of EMTALA does not readily lend itself to the conclusion that this act has no application whatsoever once a patient is admitted to the hospital. EMTALA mentions the term "emergency department" in its first subsection, 42 U.S.C. §1395dd(a). However, thereafter, the statute describes "emergency medical conditions" and the stabilization of such conditions *without* reference to whether those conditions and the medical responses to them occurred within an emergency department. *See e.g.* 42 U.S.C. §1395dd(b), (c).

Moreover, the definitional section of the statute, 42 U.S.C. §1395dd(e), defines the key words and phrases without confining them to the emergency department setting. Thus, for example, the term "transfer" is defined in EMTALA as "the movement (including the discharge) of an individual outside a hospital's *facilities*." 42 U.S.C. §1395dd(e)(4) (emphasis added). Clearly, Congress could have limited the reach of EMTALA's anti-transfer provision to the actions taken within an emergency department by specifying that the word "transfer" encompasses only a transfer from a hospital's emergency department. But, Congress did not so limit the reach of the anti-transfer provision of EMTALA.

The Sixth Circuit did not err in its treatment of the CMS' regulations.

III. THE RETROACTIVE APPLICATION OF CMS'S REGULATION

The Sixth Circuit also offered an additional reason why it would not apply CMS's 2003 regulation to this case. It held that this regulation should not be retroactively applied to this cause of action, which arose in 2002. Pet. App. 19a. Petitioner asserts that this ruling conflicts with this Court's decisions.

For reasons discussed in the preceding issue in this brief, quite apart from this retroactivity argument, the Sixth Circuit's basis for rejecting the 2003 CMS regulation was entirely appropriate. Under these circumstances, there is no reason for the Court to review the Sixth Circuit's alternate grounds for rejecting the regulation.

In addition, even the case law from this Court cited in Providence Hospital's petition does not support its position. Providence Hospital relies on the Court's decision in *Smiley v. Citibank*, 517 U.S. 735 (1996), in support of its assertion that a clarifying regulation is to be given full retroactive effect. Yet, in *Smiley* this Court indicated that an argument for the prospective only application of a regulation would have substance, "if the regulation replaced a prior agency interpretation." *Id.* at 744, n. 4.

As discussed previously, the 2003 CMS regulation on which petitioner relies replaced a 2002 proposal which would have extended EMTALA's reach to inpatients. Thus, under the very precedent that petitioner cites, the Sixth Circuit did not err in its ruling with respect to the retroactive application of the 2003 regulations.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be denied.

MARK GRANZOTTO
Counsel of Record
MARK GRANZOTTO, P.C.
225 South Troy Street, Suite 120
Royal Oak, Michigan 48067
(248) 546-4649

JULIE A. GIBSON
SMITH & GIBSON, P.C.
28411 Northwestern Hwy., Suite 1275
Southfield, Michigan 48034
(248) 353-0600

Counsel for Respondent

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No. 09-438

In The Supreme Court of the United States

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

CATHERINE E. STETSON
HOGAN LOVELLS US LLP
COLUMBIA SQUARE
555 Thirteenth Street, NW
Washington, DC 20004
(202) 637-5600
cate.stetson@hoganlovells.com

SUSAN HEALY ZITTERMAN
Counsel of Record
KITCH DRUTCHAS WAGNER VALITUTTI & SHERBROOK
One Woodward Avenue
Suite 2400
Detroit, MI 48226
(313) 965-7905
sue.zitterman@kitch.com

Counsel for Petitioner

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

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SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

In *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 119 S. Ct. 685, 142 L.Ed. 2d 648 (1999), this Court was asked to entertain the very issue now pending on certiorari—EMTALA's applicability to hospital inpatients—as an alternative argument in support of the Sixth Circuit's judgment in that case. *See* Brief for Respondent, No. 97-53, 1998 WL 649053, at *41-*47; Brief for AHA *et al.* as *amici curiae*, No. 97-53, 1998 WL 649036, at *22-*27. When *Roberts* was argued, the Assistant arguing for the United States stated that the Secretary intended to promulgate a rule to address the issue. Oral Argument Transcript, 1998 WL 846721, at *20-*21.

The Court declined, in the end, to take up in *Roberts* the issue of EMTALA's applicability to hospital inpatients. *Roberts*, 525 U.S. at 253. And it took several years, but the Secretary did issue her promised rule. It is that rule the Sixth Circuit now has declared to be of no effect in its jurisdiction—in conflict with the holdings of federal courts in several other circuits.

The Acting Solicitor General agrees with Petitioner that the Court of Appeals for the Sixth Circuit committed legal error on each of the two questions presented by the Petition. *See* Br. for the United States as Amicus Curiae at 9 (court of appeals "erred"), 13 (court of appeals "erred"), 14 (court of appeals "should have given [the relevant HHS regulation] controlling weight"), 19 (court of appeals' retroactivity

ruling was "wrong"), 21 (court of appeals' "ruling on the retroactivity issue is in error"). Yet he nonetheless is of the view that the Petition should be denied. His recommendations against a grant of certiorari are not well founded.

1. The Sixth Circuit's decision is a classic candidate for certiorari review. The dissent from the denial of rehearing en banc emphasized the "serious conflict" between the panel's decision below and the decisions of other circuits. Pet. App. 35a (Griffin, J., dissenting from denial of rehearing en banc). *Compare Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1167 (9th Cir. 2002) (statute's "stabilization requirement normally ends when the patient is admitted for inpatient care" unless admission not in good faith) and *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) ("Once EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians.") and *Collins v. DePaul Hosp.*, 963 F.2d 303, 307 (10th Cir. 1992) (no EMTALA violation where patient was screened, admitted, and treated for 26 days) and *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002) (en banc) (Barkett, J., concurring) (agreeing that "because [the plaintiff] was admitted as a patient, redress for negligence occurring during her emergency room care is available through state medical malpractice laws, rather than federal law") with Pet. App. 16a ("EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit") and *Thornton v. Southwest Detroit Hosp.*, 895

F.2d 1131, 1135 (6th Cir. 1990) (suggesting that EMTALA applied to inpatients).

Federal district courts outside of these circuits have likewise studied this entrenched split when examining the scope of EMTALA, and the "vast majority" of them have sided against the Sixth. Pet. App. 35a (Griffin, J., dissenting from denial of rehearing en banc). *See Rivera v. Hospital Episcopal Cristo Redentor*, 613 F. Supp. 2d 192 (D. P.R. 2009) ("Various circuit courts have determined that EMTALA's stabilization requirement is not applicable in situations where an individual is admitted to the hospital for further treatment.") (citing *Harry*, *Bryant*, and *Bryan*); *Morgan v. North Mississippi Med. Ctr., Inc.*, 403 F. Supp. 2d 1115 (S.D. Ala. 2005) (reviewing *Bryant*, *Bryan* and *Thornton* and adopting the approach taken in *Bryant*), *aff'd*, 225 Fed. Appx. 828 (11th Cir. 2007), *cert. denied*, 128 S. Ct. 888 (2008); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046, 1054 (E.D. Mo. 2005) ("If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation [under EMTALA] ends."); *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 447 (E.D. Pa. 2004) ("[T]he most persuasive synthesis of the law on admission as a defense to EMTALA liability is that admission is a defense so long as admission is not a subterfuge."); *Dollard v. Allen*, 260 F. Supp. 2d 1127 (D. Wyo. 2003) (citing *Bryant* and *Bryan* and concluding that EMTALA's stabilization provision does not apply to individuals admitted to the hospital for inpatient care; "once [the hospital] assumed responsibility for Plaintiff's treatment by admitting her to the medical/surgery unit, it assumed liability under state tort law for negligent treatment"); *Scott v. Hutchinson Hosp.*, 959 F. Supp. 1351 (D. Kan. 1997)

(EMTALA no longer applies to admitted inpatient). The split among the federal courts has precipitated a corresponding "shadow split" in the state courts as well. *Compare Preston v. Meriter Hosp.*, 747 N.W.2d 173 (Wis. 2008) (reviewing available federal precedents and concluding that EMTALA screening requirement does not apply to inpatients) and *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998) (same) *with Smith v. Richmond Mem. Hosp.*, 416 S.E.2d 689 (Va. 1992) (citing *Thornton* in support of its conclusion that EMTALA applies beyond admission as an inpatient). And as is evident from the regularity with which this issue has arisen across the country in the last decade and a half, the issue is a recurring one.

The Acting Solicitor General nonetheless argues that the split the Petition identifies—one already extant even when *Roberts* was decided—is "relatively shallow" and should be permitted to "percolat[e]" further. U.S. Br. 15. But the lengthy footnote 7 in the Acting Solicitor General's submission (not to mention the raft of federal district court decisions that go largely untreated therein) suggests that "relatively shallow" split is far deeper and more entrenched than the Acting Solicitor General would have it. *See id.* at 17 n.7 (citing multiple decisions described as addressing but not "squarely deciding" the issue presented in this Petition). To be clear: A conflict over this precise question has been brewing for the last decade and a half. With the Sixth Circuit's decision here, the conflict first presaged with *Thornton* has come to a full boil—it is very real, and certainly fully established. And where the Acting Solicitor General

has acknowledged that the Sixth Circuit's decision was wrong, further "percolation" would serve no benefit.[1]

2. The Acting Solicitor General also posits that the Court should decline review because HHS might "initiate a rulemaking process" to "reconsider" the 2003 CMS regulation that essentially codified *Bryan* and *Bryant* (and expressly rejected *Thornton*). U.S. Br. 18.[2] But the Acting Solicitor General elsewhere recognizes that the policy articulated in CMS's regulation was reaffirmed as recently as 2008. See U.S. Br. 6 n.3. And whatever the likelihood that HHS will in future "reconsider" a policy it only recently articulated and even more recently reaffirmed, this Court should not decline review on the mere theory that the Department might eventually revisit a regulation that one circuit has declared a dead letter, cementing a current circuit conflict in the process.

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[1] Indeed the Solicitor General has recommended the grant of certiorari to resolve conflicts as or more "shallow" as that claimed here. *See, e.g.*, Brief for the United States as Amicus Curiae, *Virginia Office for Protection and Advocacy v. Reinhard* (No. 09-529) (recommending grant of certiorari in case presenting 1 to 1 circuit split).

[2] The Acting Solicitor General suggests that HHS is "committed to promulgating a request for comment in 2010 and a notice of proposed rulemaking in 2011." U.S. Br. 18. But a request for comment is just a request, and a proposed rulemaking is still just a proposal. It took HHS *four years*, after its stated commitment to the effort during the *Roberts* oral argument, see supra at 1, to promulgate a proposed rule addressing EMTALA's application after inpatient admission; to revise the proposal based on extensive comments; and to finally promulgate 42 C.F.R. § 489.24(d)(2). On that time frame, HHS might (or might not) by 2014 or 2015 have implemented a different policy. And in the meantime, the Sixth Circuit's erroneous ruling would stand.

Legal issues of national importance are constantly being considered, and reconsidered, by federal agencies. It would radically hamstring this Court (not to mention countless parties seeking this Court's guidance) if the Court were to refrain from deciding issues that an expert agency already has pronounced upon but may at some future time revisit. The conflict and resulting uncertainty created by the Sixth Circuit exist now. And guidance is keenly needed now to resolve the disagreement among the circuits about the scope and application of EMTALA and its implementing regulations, and to supply needed certainty to physicians and hospitals in their daily practice.

3. The Acting Solicitor General also offers a limited menu of what he calls various "atypical" elements of this case that, in his view, weigh against review. His concerns are misplaced. That this case is "interlocutory" (summary judgment was reversed) is irrelevant. The questions presented are purely of law, and they are completely dispositive of the case. The Acting Solicitor General also soothingly argues that this hospital might yet prevail on remand—after, that is, expending yet more money and time defending against a demonstrably legally deficient claim. See U.S. Br. 19. That hypothetical result is cold comfort to the other hospitals and hospital systems in the Sixth Circuit, who, absent review here and certainly regardless of the outcome on remand, must continue to operate pursuant to the appeals court's concededly misguided interpretation of the law.

The Acting Solicitor General also contends that this Court's consideration of the case could be "color[ed]" by the fact that plaintiff is a non-patient third party,

which presents a potential statutory standing issue. U.S. Br. 20. That is again not so. The court of appeals held that respondent had standing. Petitioner has not challenged that holding, on which (unlike the issues Petitioner *did* raise) there is no split of authority. And the legal question presented here—whether EMTALA applies to inpatients—is simply not affected by the fact that the respondent here was not herself the inpatient.

4. The Acting Solicitor General also substantially underestimates the practical consequences of denying review. *See* U.S. Br. 20.

By extending EMTALA to inpatient care, the Sixth Circuit has created an inconsistent two-tiered system of care, regulation, penalties, fines, and tort litigation—all depending on whether a patient is admitted through the emergency department with an emergency medical condition, or by another route. Patients admitted as inpatients—whether through the ER or by their physician—are protected by state tort law governing medical malpractice, the hospital's Medicare Conditions of Participation, and state quality assurance and licensing laws. But under the Sixth Circuit's decision, patients admitted through the ER with an emergency medical condition are now entitled to another federalized care requirement: ongoing treatment "as may be required to stabilize the medical condition," *i.e.*, so as to ensure that no material deterioration in the patient's emergency medical condition occurs throughout the hospitalization, or an "appropriate" transfer. And for those inpatients admitted through the ER, the federal stabilization requirement apparently applies indefinitely beyond admission, meaning that "stabilizing care" may be required for days, weeks, or months.

Importing EMTALA's "stabilization" standard to hospital inpatients also has the potential to transform every malpractice claim for post-discharge complications by those admitted through the ER into a federal "failure to stabilize" claim under EMTALA. In addition to forcing already strained federal court dockets to accommodate mine-run medical-malpractice cases, such "federal malpractice" claims undermine state tort principles (not to mention thwarting EMTALA's own instruction that the statute's provisions are not to preempt any available state tort law). They are not subject to many procedural state tort reform provisions, including expert-witness limitations, affidavits of merit, shorter limitations periods on malpractice claims, and letters or notices of intent to bring a claim. (For one example, EMTALA's two-year statute of limitations is double the time period for bringing a medical malpractice claim in Ohio.) Peer-review protections also exist in many states to promote the candor needed to ensure participation and effective retrospective review and quality care; but those protections do not apply in federal court.

Extending EMTALA's reach to inpatients also will change the way physicians practice medicine in the inpatient setting. For patients admitted through the ER with an emergency medical condition, protocols would have to be established to track (and ensure EMTALA compliance as to) those patients. Patient complaints related to insufficient stabilizing care or premature discharge while an inpatient will place hospitals at risk for civil fines, substantial expenses in responding to CMS investigations, and potential disqualification from Medicare. Physicians, too, would face civil fines and Medicare disqualification. See 42

U.S.C. § 1395dd(d)(1). The clinical decision to discharge is a matter of physician judgment, not a hospital decision; yet under EMTALA, hospitals will be held directly liable (and potentially excluded from Medicare participation) for the clinical choices of their physicians at the time of patient discharge. EMTALA fines and potential CMS investigations will push physicians toward practicing defensive medicine, lest they risk federal penalty. And much of that additional layer of uncalled-for care—whether needless diagnostic tests or excessive hospital stays—will be unreimbursed, further straining the nation's health care system.

The Sixth Circuit's ruling also poses an enforcement conundrum for HHS itself. The decision establishes a higher bar for EMTALA compliance by hospitals and physicians in the states of Michigan, Ohio, Kentucky, and Tennessee than exists in all other states. CMS's Regional Office in Chicago enforces EMTALA in Michigan and Ohio as well as in Illinois, Indiana, Minnesota, and Wisconsin. The Regional Office in Atlanta enforces EMTALA in Kentucky and Tennessee in addition to Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina. Under the Sixth Circuit's decision, the Chicago and Atlanta Regional Offices now have two different EMTALA standards that apply to the states within their respective regions. Similarly, two different standards have been articulated for OIG enforcement—one for hospitals and physicians in Michigan, Ohio, Kentucky, and Tennessee and another for hospitals and physicians everywhere else. And even if HHS were to view itself as not bound by the Sixth Circuit's decision, individuals in those states are still likely to call upon HHS to investigate alleged

EMTALA violations under the Sixth Circuit's holding. At a minimum, then, this disparity between the states (and among states in Regional Offices) will engender unnecessary work for —and risks damaging the reputation of—HHS. For if a hospital within the Sixth Circuit purportedly violates EMTALA by failing to "stabilize" an inpatient, shall HHS investigate? Shall it decline ever to investigate? If the former, how can HHS uniformly enforce its regulations within a Regional Office? And if the latter, how can HHS ignore the declaration of the Sixth Circuit as to the law applicable there?

The practical problems presented by the Sixth Circuit's decision are many, and they are real. The Acting Solicitor General underestimates them.

5. One other path suggests itself after review of the Acting Solicitor General's submission: Summary reversal. The Acting Solicitor General candidly agrees that the Sixth Circuit committed multiple errors. *See* U.S. Br. 9, 13, 14, 17, 19, 21. If this Court declines to give these issues a full treatment on the merits, it should instead summarily reverse the Sixth Circuit's erroneous ruling.

CONCLUSION

For the foregoing reasons, and those stated in the petition, the petition should be granted and the judgment below reversed or summarily reversed.

Respectfully submitted.

SUSAN HEALY ZITTERMAN
COUNSEL OF RECORD
KITCH DRUTCHAS WAGNER
VALITUTTI & SHERBROOK
One Woodward Avenue
Suite 2400
Detroit, Michigan 48226
(313) 965-7905
sue.zitterman@kitch.com

CATHERINE E. STETSON
HOGAN LOVELLS US LLP
COLUMBIA SQUARE
555 Thirteenth Street, NW
Washington, DC 20004
(202) 637-5600
cate.stetson@hoganlovells.com

Counsel for Petitioner

No. 09-438

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v.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

NEAL KUMAR KATYAL
Acting Solicitor General
Counsel of Record

TONY WEST
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

MELISSA ARBUS SHERRY
Assistant to the Solicitor General

MICHAEL S. RAAB
DANIEL J. LENERZ
Attorneys

Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

QUESTIONS PRESENTED

The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, requires a hospital with an emergency department that participates in the Medicare program to provide "an appropriate medical screening examination" to any individual who "comes to the emergency department" of the hospital to determine whether that individual has an "emergency medical condition." 42 U.S.C. 1395dd(a). In addition, if any individual "comes to a hospital" with an "emergency medical condition," the hospital is required either to provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or to transfer that individual to another hospital in accordance with certain statutory conditions. 42 U.S.C. 1395dd(b) and (c). The questions presented are:

1. Whether EMTALA's coverage terminates upon the hospital's good faith admission as an inpatient of an individual with an emergency medical condition.

2. Whether a 2003 regulation promulgated by the Department of Health and Human Services that clarifies the scope of a participating hospital's obligations under EMTALA may be applied to conduct occurring prior to its issuance.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. The Emergency Medical Treatment and Labor Act (EMTALA or Act), 42 U.S.C. 1395dd, was originally enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 164. Congress was responding to "a growing concern about the provision of adequate emergency room medical services to individu-

als who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, 5 (1985) (*1985 House Report*). The Act was primarily designed to address "patient dumping," the practice of turning away or transferring indigent patients without evaluation or treatment. See *Harry* v. *Marchant*, 291 F.3d 767, 772-773 (11th Cir. 2002); *Summers* v. *Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1136 (8th Cir. 1996) (en banc).

EMTALA imposes two principal obligations on hospitals with emergency departments that have entered into Medicare provider agreements with the Secretary of Health and Human Services (HHS). 42 U.S.C. 1395dd(e)(2). *First*, when "any individual" "comes to the emergency department" of a participating hospital and a request is made on the individual's behalf for examination or treatment for a medical condition, the Act requires the hospital to provide "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition * * * exists." 42 U.S.C. 1395dd(a); see 42 C.F.R. 489.24(b) (The phrase "[c]omes to the emergency department" means, *inter alia*, that an individual presents at the "dedicated emergency department" and requests examination and treatment for a "medical condition," or presents "on hospital property" and requests examination and treatment for an "emergency medical condition.").

Second, if a participating hospital determines that an individual who "comes to a hospital" is suffering from an emergency medical condition, the hospital must either (A) "within the staff and facilities available at the hospi-

tal," provide "for such further medical examination and such treatment as may be required to stabilize the medical condition," or (B) transfer the individual to another hospital in accordance with the provisions of Subsection (c). 42 U.S.C. 1395dd(b)(1). Subsection (c) states that, "[i]f an individual at a hospital has an emergency medical condition which has not been stabilized[,] * * * the hospital may not transfer the individual unless" (i) the individual (or a legally responsible person acting on the individual's behalf) makes an informed, written request to be transferred; (ii) a physician has signed a certification that the medical benefits outweigh the risks of the transfer; or (iii) "if a physician is not physically present in the emergency department at the time an individual is transferred," a qualified medical person, in consultation with a physician, has made the required risk/benefit determination. 42 U.S.C. 1395dd(c)(1)(A).[1]

The phrase "emergency medical condition" is defined as a condition "manifesting itself by acute symptoms of sufficient severity * * * such that the absence of immediate medical attention could reasonably be expected to result in * * * serious jeopardy [to the health of the individual or her unborn child], * * * serious impairment to bodily functions, or * * * serious dysfunction of any bodily organ or part." 42 U.S.C. 1395dd(e)(1)(A). The term "to stabilize" means "to provide such medical treatment of the [emergency medical] condition as may be necessary to assure, within reasonable medical prob-

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[1] The transfer must also be an "appropriate transfer," 42 U.S.C. 1395dd(c)(1)(B), which means that the receiving hospital must agree to accept the transfer and to provide appropriate medical treatment, and the sending hospital must forward all relevant medical records, provide qualified personnel for the transfer, and take actions to minimize the risk of transfer. 42 U.S.C. 1395dd(c)(2).

ability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." 42 U.S.C. 1395dd(e)(3)(A); see 42 U.S.C. 1395dd(e)(3)(B) (similar definition of "stabilized"). And the Act defines "transfer" as "the movement (including the discharge) of an individual outside a hospital's facilities." 42 U.S.C. 1395dd(e)(4).

EMTALA confers a private right of action on "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [EMTALA]." 42 U.S.C. 1395dd(d)(2)(A) (permitting recovery of amount of "damages available for personal injury under the law of the State in which the hospital is located"). The Secretary of HHS may also impose civil monetary penalties on participating hospitals and on physicians for negligent violations of the Act. 42 U.S.C. 1395dd(d)(1).

2. In May 2002, the Centers for Medicare & Medicaid Services (CMS), within HHS, published a proposed rule to clarify, among other things, an issue that had "occasionally" been raised regarding whether EMTALA applied to individuals admitted to a hospital as inpatients. See 67 Fed. Reg. 31,475; see also *Roberts* v. *Galen of Va., Inc.*, 525 U.S. 249 (1999) (No. 97-53), 12/1/98 Tr. of Oral Argument at 20-21 (advising the Court that HHS was planning to engage in rulemaking on that question). The proposal was that EMTALA "would apply to inpatients only under limited circumstances"—namely, it would cover an individual who initially "come[s] to the emergency room" requesting care for an emergency medical condition, is admitted as an inpatient before that condition is "stabilized," and is not thereafter "stabilized" in any non-transient manner prior to transfer. 67 Fed. Reg. at 31,475. The proposed rule

would have further clarified that, except for these "limited circumstances," "EMTALA does not apply to hospital inpatients." *Ibid.* The agency expressed concern that "permitting inpatient admission to end EMTALA obligations would provide an obvious means of circumventing" the Act's requirements, but also noted that, although "the legislative history of EMTALA is replete with references to the problem of individuals denied emergency medical care at hospital emergency rooms, * * * there is no explicit reference to similar problems faced by hospital inpatients." *Ibid.*[2]

Following the receipt of comments, in September 2003, CMS promulgated a final rule "interpreting hospital obligations under EMTALA as ending once the individuals are admitted to the hospital [for] inpatient care," unless the hospital admission was not in "good faith with the intention of providing treatment." 68 Fed. Reg. 53,244-53,245. The agency explained that several courts of appeals had interpreted EMTALA's obligations as ending upon admission, and that state law remedies and the conditions of participation for a hospital's participation in Medicare provided adequate means to protect inpatients. *Id.* at 53,245.

The adopted regulation thus provides that a hospital satisfies EMTALA's requirements with respect to an individual found to have an emergency medical condition if it "admits that individual as an inpatient in good faith

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[2] The proposed rule was consistent with a view expressed in the preamble to an earlier version of the regulations, in which the agency interpreted the stabilization requirement "to mean, for example, that if a hospital were to admit and then transfer a patient before his or her condition is stabilized * * * it would be a violation of [EMTALA]." 53 Fed. Reg. 22,517 (1988) (proposed rule); see 59 Fed. Reg. 32,092 (1994) (summarizing proposed rule).

in order to stabilize the emergency medical condition." 42 C.F.R. 489.24(d)(2)(i); see 42 C.F.R. 489.24(a)(ii) ("If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section."); cf. 42 C.F.R. 489.24(d)(2)(iii) ("A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation."). The regulation defines "inpatient" as "an individual who is admitted to a hospital for bed occupancy * * * with the expectation that he or she will remain at least overnight." 42 C.F.R. 489.24(b).[3]

3. On December 13, 2002, Marie Moses-Irons brought her husband, Christopher Howard, to the emergency department of petitioner Providence Hospital. Pet. App. 3a. Howard's symptoms included severe headaches, muscle soreness, high blood pressure, vomiting, slurred speech, disorientation, hallucinations, and delusions. *Ibid.* Emergency room physicians admitted Howard as an inpatient to conduct more tests. *Ibid.* He was ultimately diagnosed with a migraine headache and atypical psychosis with delusional disorder and, although there allegedly were plans to transfer Howard to the psychiatric unit, he was released from the hospital

[3] In 2008, HHS examined whether EMTALA's "specialized care" provisions would require hospitals with specialized capabilities to accept the transfer of an individual who was an inpatient at the admitting hospital. See 73 Fed. Reg. 48,656-48,661. The agency ultimately clarified that "once an individual is admitted in good faith by the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual even if the individual remains unstabilized[,] and a hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual." *Id.* at 48,661.

on December 19, 2002. *Id.* at 4a-5a. Ten days later, Howard murdered his wife. *Id.* at 5a.

In 2004, the representative of Moses-Iron's estate commenced this suit against petitioner alleging a violation of EMTALA and state law negligence claims. Pet. App. 5a.[4] Petitioner filed a motion to dismiss, arguing, *inter alia*, that respondent lacked standing to bring an EMTALA claim because she was not the individual who had sought treatment from the hospital. *Ibid.* The district court denied that motion, concluding that "the plain language of the statute does not preclude a lawsuit by the injured third party." *Ibid.* (quoting C.A. App. 181).

Petitioner then moved for summary judgment, again challenging respondent's standing and asserting two other grounds: (1) EMTALA does not impose any obligations on a hospital once an individual is admitted as an inpatient, and (2) there was no EMTALA violation because Howard was properly screened and was not diagnosed as having an emergency medical condition. Pet. App. 6a, 10a. The district court granted summary judgment to petitioner because, "regardless of the standing issue," "[t]he hospital admitted Howard and did not turn him away" and, after a proper screening, the hospital did not recognize an "emergency medical condition." *Id.* at 7a (quoting C.A. App. 216). The court declined to exercise supplemental jurisdiction over respondent's state-law claims. *Id.* at 7a.

4. The court of appeals reversed and remanded for further proceedings. Pet. App. 1a-28a. As an initial matter, the court agreed that respondent had standing to sue under EMTALA because, the court explained, the

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[4] The complaint also named an individual physician as a defendant, but the physician was dismissed, Pet. App. 26a-28a, and is not a petitioner before this Court.

plain language of the statute broadly confers a private right of action on "*any* individual who suffers personal harm as a direct result" of the hospital's violation. *Id.* at 10a-15a (emphasis added).

The court then held that "EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit." Pet. App. 16a. Reasoning that EMTALA "requires 'such treatment as may be required to stabilize the medical condition,' § 1395dd(b), and forbids the patient's release unless his condition has 'been stabilized,' § 1395dd(c)(1)," the court concluded that "EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely." *Ibid.*; see *id.* at 17a ("Thus, the statute requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well.").

The court refused to defer to HHS's regulation providing that a hospital's EMTALA obligations are satisfied upon the good faith admission of the individual as an inpatient, finding the regulation "contrary to EMTALA's plain language." Pet. App. 18a. The court thought it "unreasonable" to treat admission, in and of itself, as the equivalent of the "treatment as may be required to stabilize" that the Act requires. *Ibid.* In the alternative, the court concluded that it would be inappropriate to apply HHS's interpretation here because the regulation was promulgated after the conduct at issue in this case. *Id.* at 19a.

Finally, the court of appeals held that whether the hospital conducted an appropriate screening and found no emergency medical condition, and whether the hospi-

tal believed Howard was stabilized upon discharge, raised disputed issues of fact for the jury to decide. See Pet. App. 20a-26a.

5. The court of appeals denied rehearing en banc with one judge dissenting. Pet. App. 34a-36a.

DISCUSSION

The court of appeals erred in holding that EMTALA's coverage unambiguously continues after an individual has been admitted in good faith to the hospital as an inpatient. Congress did not speak directly to this issue, and HHS is entitled to deference as the expert agency. Nonetheless, review is not warranted at this time. The conflict among the circuits is shallow, HHS has committed to initiating rulemaking to reconsider this issue in the coming year, and the case is in an interlocutory posture and is atypical in several respects that further weigh against review. The Court therefore should deny the petition for a writ of certiorari.

A. EMTALA's Coverage Does Not Unambiguously Continue Once An Individual Has Been Admitted In Good Faith As A Hospital Inpatient

The familiar two-step framework established by *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), governs this case. At the first step, a court asks "whether Congress has directly spoken to the precise question at issue"; if Congress has unambiguously expressed its intent, the court must give effect to that intent. *Ibid.* If the statute is silent or ambiguous, however, the court must determine "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. Congress did not directly answer the question presented in this case—but in a 2003 regulation promulgated after

notice and comment HHS did. The court of appeals should have deferred to the agency's "permissible construction of the statute." *Ibid.*

1. The statutory text does not unambiguously provide that EMTALA's coverage continues after an individual is admitted to the hospital as an inpatient. To be sure, nothing in Subsection (b) expressly states that EMTALA's requirements are satisfied upon admission to the hospital as an inpatient. But there is also no express statement that coverage will continue indefinitely, beyond appropriate screening and treatment in the emergency room.

a. On the one hand, Subsection (b) is written in expansive terms. It refers to any individual who "comes to a hospital" and is determined to have an "emergency medical condition." 42 U.S.C. 1395dd(b)(1). It then states that the hospital must either (A) provide, "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition," or (B) transfer the individual in accordance with Subsection (c). *Ibid.* And the Act measures stabilization under Subsection (b) by whether the condition will deteriorate if the individual is moved "from a facility" or "outside a hospital's facilities," 42 U.S.C. 1395dd(e)(3) and (4). In contrast, the medical screening requirement in Subsection (a) refers to any individual who "comes to the emergency department" and requires the hospital to provide an examination "within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department." 42 U.S.C. 1395dd(a). As respondent argues (Br. in Opp. 10), the references to the "emergency department" in Subsection (a) compared to the absence of any such

mention in Subsection (b), or in the definitions of "to stabilize" or "transfer," could suggest that the stabilization requirement applies to the treatment of "emergency medical conditions," whether or not they exist in the "emergency department." See *Thorton* v. *Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990) ("[T]his change in wording" leads to a "reasonable inference" that the stabilization requirement applies "regardless of whether the patient stays in the emergency room.").

On the other hand, Subsection (b) permits a hospital to transfer an individual before he is stabilized only in accordance with Subsection (c)—*i.e.*, only if, *inter alia*, a physician signs a certification attesting to the risks and benefits of the transfer. 42 U.S.C. 1395dd(c)(1)(A)(ii). And it further provides an alternative way of effectuating an appropriate transfer if a "physician is not physically present in the emergency department" at that time. 42 U.S.C. 1395dd(c)(1)(A)(iii). Congress's decision to condition transfers on whether a physician is physically present in the emergency department could indicate that "it meant to be speaking in subsection (c) about decisions to be made in the emergency room." See *James* v. *Sunrise Hosp.*, 86 F.3d 885, 889 (9th Cir. 1996). But see *Lopez-Soto* v. *Hawayek*, 175 F.3d 170, 176 (1st Cir. 1999) (rejecting that reading and arguing that "the provision addresses only a discrete subset of transfer circumstances," whereas the more generally applicable provision does not impose "any limitation on where certification decisions must be made").

In other respects, the stabilization requirement can be read as one that is limited in duration. For example, it is keyed to the identification of an "emergency medical condition," which is defined as a condition manifesting

itself by "acute symptoms" requiring "immediate medical attention." 42 U.S.C. 1395dd(e)(1). Those words connote a sense of imminence and urgency that is in some tension with an ongoing stabilization obligation of indefinite duration. The Act also includes protections for women in labor and defines "to stabilize" in that context as "to deliver (including the placenta)." 42 U.S.C. 1395dd(e)(3). This could suggest that EMTALA was intended to apply to inpatients, because Congress intended to cover pregnant women until "delivery," which could occur after admission to the maternity ward. Cf. *Lopez-Soto*, 175 F.3d at 176-177. But EMTALA's inclusion of pregnant women in labor imposes an obligation on the hospital that is inherently limited in duration; it does not suggest that Congress necessarily envisioned that the Act would govern the hospital's actions on an open-ended basis.

b. As a general matter, EMTALA's legislative history makes clear that Congress was primarily focused on the problem of hospitals dumping indigent and uninsured individuals from hospital emergency rooms. See, *e.g.*, *1985 House Report*, Pt. 1, at 27 ("The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance."); *1985 House Report*, Pt. 3, at 6 ("The Judiciary Committee shares the concern of the Ways and Means Committee that appropriate emergency room care be provided."); 131 Cong. Rec. 28,568 (1985) (Sen. Durenberger); *id.* at 28,569 (Sen. Kennedy); *ibid.* (Sen. Heinz).

In discussing the EMTALA obligations more specifically, including the stabilization requirement, the legislative history at times suggests a focus on treatment

provided within the emergency department. For example, the report of the House Ways and Means Committee described the stabilization obligation as requiring "hospital emergency departments" to "provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers." *1985 House Report*, Pt. 1, at 4; see 131 Cong. Rec. 29,829 (1985) (Sen. Stark). During Senate floor debates, at least one Senator's comments suggested that the obligations imposed by EMTALA were intended to have a temporal limit. See *id.* at 28,569 (Sen. Dole) ("Under the provision[s] of this amendment, a hospital is charged *only* with the responsibility of providing an adequate *first response* to a medical crisis.") (emphases added); see also *ibid.* (Sen. Dole) (describing patient dumping as a practice "whereby a hospital, for purely financial reasons, refuses to *initially* treat or stabilize an individual with a true medical emergency") (emphasis added). But while Congress's primary focus was on patient dumping from hospital emergency rooms, the legislative history also suggests a more inclusive belief that "all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress." *Id.* at 28,568 (Sen. Durenberger).

c. In sum, a review of the statutory text, structure, and purpose of EMTALA reveals that Congress did not speak "directly * * * to the precise question at issue." *Chevron*, 467 U.S. at 842. The court of appeals therefore erred when it concluded that EMTALA's coverage unambiguously continues after an individual has been admitted as a hospital inpatient. See Pet. App. 16a-19a. Nor does the legislative history suggest that Congress

clearly intended that EMTALA's coverage would continue after admission as an inpatient.

2. Congress has expressly authorized the Secretary of HHS to promulgate rules and regulations interpreting and implementing EMTALA, see 42 U.S.C. 1302(a); 1395hh(a)(1), and to administer the civil monetary fine provisions of EMTALA, see 42 U.S.C. 1395dd(d)(1)(A) and (B) (incorporating 42 U.S.C. 1320a-7a). Accordingly, as the court of appeals recognized (Pet. App. 18a-19a), the Secretary's regulations, adopted after notice and comment, are entitled to *Chevron* deference.

In 2003, HHS promulgated a final rule clarifying that a hospital's obligations under EMTALA are satisfied once it "admits [an] individual as an inpatient in good faith in order to stabilize the emergency medical condition." 42 C.F.R. 489.24(d)(2); see 42 C.F.R. 489.24(a)(ii); see also 73 Fed. Reg. 48,659 (2008) (clarifying "that if an individual presents to the admitting hospital that has a dedicated emergency department, is provided an appropriate medical screening examination and is found to have an emergency medical condition, and is admitted as an inpatient in good faith for stabilizing treatment of an emergency medical condition, then the admitting hospital has met its EMTALA obligation to that individual, even if the individual remains unstable").

For all the reasons explained above, that interpretation is a reasonable one. Although it is not the only permissible reading, the HHS regulation is consistent with the text, structure, purpose, and history of EMTALA, and the court of appeals should have given it "controlling weight." *Chevron*, 467 U.S. at 844.

B. Further Review Is Not Warranted At This Time

1. Before the HHS regulation was promulgated, three courts of appeals, including the Sixth Circuit in dicta, had addressed the question presented. No other court of appeals has examined this question in light of the current regulation.[5] The circuit split is relatively shallow and further percolation is warranted.

In *Thorton*, 895 F.2d at 1135, the Sixth Circuit reviewed EMTALA's text and legislative history and stated that "[e]mergency care must be given until the patient's emergency medical condition is stabilized." The court found it significant that Subsection (a) refers to the "emergency department" on several occasions, whereas Subsection (b) refers to the "hospital." *Id.* at 1134. Looking to the legislative history, the court explained that Congress sought to ensure that emergency care is provided and, "[a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital." *Id.* at 1135. Because the plaintiff's condition had been stabilized at the time of her discharge, however, the court affirmed the dismissal of the case. The Sixth Circuit's discussion of EMTALA's coverage in *Thorton* therefore appears to have been dictum.

Several years later, in *Bryan* v. *Rectors and Visitors of the University of Virginia*, 95 F.3d 349 (1996), the Fourth Circuit held, contrary to the Sixth Circuit's view in *Thorton*, that the EMTALA stabilization requirement applies only "in the immediate aftermath of the act of

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[5] In *Torretti* v. *Main Line Hospital, Inc.*, 580 F.3d 168, 175-176 (2009), the Third Circuit examined and deferred to the HHS regulation with respect to outpatients.

admitting" and while the hospital "consider[s] whether it [will] undertake longer-term full treatment or instead transfer the patient to a hospital" that will do so. *Id.* at 352. The court viewed EMTALA as a "limited 'anti-dumping' statute, not a federal malpractice statute," that has the "sole purpose" of "deal[ing] with the problem of patients being turned away from emergency rooms for non-medical reasons." *Id.* at 351. Once the hospital accepts the patient, the court reasoned, the patient's care becomes the legal responsibility of the hospital and is governed by state tort law. *Id.* at 351-352. The court also found support for its interpretation in the statutory phrase "to stabilize" which, the court explained, is defined "entirely in connection with a possible transfer and without any reference to the patient's long-term care within the system." *Id.* at 352.

In 2002, shortly before the HHS regulation was promulgated, the Ninth Circuit held that "the stabilization requirement normally ends when a patient is admitted for inpatient care." *Bryant* v. *Adventist Health Sys./W.*, 289 F.3d 1162, 1167. The court acknowledged that the term "'stabilize' appears to reach a patient's care after the patient is admitted to the hospital for treatment," but it explained that "the term is defined only in connection with the transfer of an emergency room patient." *Ibid.* While recognizing the concerns raised by the Sixth Circuit in *Thorton*, the court ultimately agreed with the Fourth Circuit, holding that "EMTALA's stabilization requirement ends when an individual is admitted for inpatient care," unless "a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements." *Id.* at 1168-1169; see also *Morgan* v. *North Miss. Med. Ctr., Inc.*, 225 Fed. Appx. 828 (11th Cir. 2007) (affirming, without opinion, district

court decision adopting *Bryant* rule), cert. denied, 552 U.S. 1098 (2008).[6]

The Sixth Circuit in this case adopted the dictum from its prior decision in *Thorton* as a holding, despite HHS's promulgation of its regulation in the interim. And it did so without citing the conflicting decisions in the Fourth and Ninth Circuits.[7]

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[6] As respondent argues (Br. in Opp. 7-8), the underlying facts in both *Bryan* and *Bryant* are distinct in at least one respect: the patients did not allege an inappropriate "transfer," as that term is defined in EMTALA. In *Bryan*, there was no transfer at all; the individual died while a patient in the admitting hospital. See 95 F.3d at 350; 42 U.S.C. 1395dd(e)(4) (defining "transfer" as excluding the movement of a person declared dead). And in *Bryant* there was no allegation that the transfer itself violated EMTALA. See 289 F.3d at 1164. As noted above, both courts relied, in part, on the fact that the stabilization requirement is keyed to a "transfer," and some courts have held that EMTALA's stabilization requirement is not triggered unless there has been such a transfer. See p.17 n.7, *infra*. Neither court, however, rested on that rationale as the basis for its decision.

[7] The First and Eleventh Circuits have also addressed the scope of EMTALA's stabilization requirement, but have not squarely decided the question presented here. Both courts have relied on the definition of "to stabilize" to hold that "a hospital cannot violate the duty to stabilize unless it transfers [the] patient." *Alvarez-Torres* v. *Ryder Mem'l Hosp., Inc.*, 582 F.3d 47, 51-53 (1st Cir. 2009) (explaining that the definition of "to stabilize" shows that "the duty to stabilize attaches when a hospital transfers a patient" and does not "create a duty of care for medical services provided while a patient remains in the hospital"); *Harry* v. *Marchant*, 291 F.3d 767, 771 (11th Cir. 2002) (EMTALA "does not set forth guidelines for the care and treatment of patients who are not transferred."); cf. *id.* at 775 (Barkett, J., concurring) ("agree[ing]" with the majority that because the plaintiff "was admitted as a patient, redress" is not available under EMTALA). The First Circuit has also held that the stabilization requirement attaches regardless of where in the hospital a patient first presents with an emergency medical condition. See *Lopez-Soto*, 175 F.3d at 172-177; *id.* at 177 n.4 (declining to

2. The relatively shallow circuit split does not warrant the Court's review at this time. HHS has informed this Office that it is committed to initiating a rulemaking process that will reconsider the policy articulated in its 2003 regulation. Specifically, HHS is committed to promulgating a request for comment in 2010 and a notice of proposed rulemaking in 2011. In these circumstances, the Court should not grant review to address the same question.

Interpreting EMTALA to extend beyond the emergency department, as the court of appeals did, raises other questions not answered by Congress and best suited for expert agency consideration. For example, when HHS proposed in 2002 to extend EMTALA's coverage to some inpatients, it did not propose to extend it to *all* inpatients. See 67 Fed. Reg. at 31,475-31,476; see Br. in Opp. 10 (arguing that the statutory text does not "readily lend itself" to the conclusion that the Act has "no application whatsoever once a patient is admitted to the hospital"). Thus, if EMTALA's coverage were to extend in some circumstances beyond the point of admission as an inpatient, a further question would arise: would EMTALA's coverage be of open-ended duration, or would there be some temporal limitation apart from the point of admission? Cf. 42 U.S.C. 1395dd(e)(3) and (4) (defining "to stabilize" as requiring the hospital to

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address the temporal limitations of such a requirement and pointing to the Fourth Circuit's decision in *Bryan* as an example of a way in which courts have "cabin[ed] such undue expansion of EMTALA into the malpractice realm"); cf. *Smith* v. *Richmond Mem'l Hosp.*, 416 S.E.2d 689, 691-694 (Va. 1992) (holding that the transfer provisions of Subsection (c) apply regardless of whether the individual initially presented with an emergency medical condition, as long as he had an unstabilized emergency medical condition at the time of transfer).

provide treatment such that "no material deterioration of the condition is likely *to result from or occur during* the transfer," *i.e.*, *"the movement* * * * of an individual outside a hospital's facilities") (emphases added). These are questions that would benefit greatly from HHS's expertise and experience, and from public comment during a rulemaking process, as HHS reconsiders how best to effectuate Congress's intent. Accordingly, the prudent course would be to deny review at this time.

3. Forgoing review is appropriate for additional reasons as well. First, the court of appeals' decision is interlocutory. The court reversed the district court's grant of summary judgment and remanded for further proceedings. Pet. App. 28a. If respondent prevails on remand, petitioner will be able to raise its current contentions—together with any other issues concerning the application of EMTALA that may arise as a result of the additional proceedings on remand—in a single petition for a writ of certiorari. See *Major League Baseball Players Ass'n* v. *Garvey*, 532 U.S. 504, 508 n.1 (2001) (per curiam).

Second, this is an atypical case. The hospital's alleged EMTALA violation occurred before the regulation at issue was promulgated. The court of appeals declined to defer to the agency's regulation on that independent basis. See Pet. App. 19a-20a. And while that ruling was wrong, it does not independently warrant this Court's review. See pp. 21-22, *infra*. In addition, the plaintiff in this case is a non-patient, third party. See 42 U.S.C. 1395dd(d)(2)(A) (providing private right of action for "[a]ny individual who suffers personal harm as a direct result" of the hospital's EMTALA violation); *1985 House Report*, Pt. 3, at 6 (explaining, prior to the 1986 enactment of EMTALA, that the proposed private right of

action is being amended to make clear that it authorizes only actions "brought by the individual patient who suffers harm as a direct result of [a] hospital's failure to appropriately screen, stabilize, or properly transfer that patient"). The court of appeals nevertheless concluded that respondent had standing to sue under EMTALA. Petitioner does not ask the Court to review that determination. But that is a threshold issue about respondent's ability to invoke EMTALA at all, and it could color consideration of the principal question on which petitioner does seek review.

Finally, the practical consequences of denying review while the agency engages in further rulemaking are likely to be minimal. In the almost 25 years since EMTALA was enacted, only three courts of appeals have directly addressed whether EMTALA's coverage continues after a hospital admits an individual in good faith as an inpatient, and only one court of appeals—the Sixth Circuit in this case—has addressed HHS's regulation interpreting EMTALA's stabilization requirement as applied to inpatients. Whether there is EMTALA liability or not, hospitals have an incentive to furnish appropriate treatment to individuals who have been admitted as inpatients. State tort law could ordinarily be expected to provide a remedy to an inpatient for negligent care. See, *e.g.*, *Bryant*, 289 F.3d at 1169; *Bryan*, 95 F.3d at 351-352; 68 Fed. Reg. at 53,244-53,245; 73 Fed. Reg. at 48,656. And hospitals with emergency departments participating as providers under Medicare—the category of hospitals to which EMTALA applies—are independently required by federal law to have a process in place that identifies patients who are likely to suffer adverse health consequences upon discharge if there is no adequate planning, and to provide a dis-

charge plan where appropriate. See 42 C.F.R. 482.43, 489.24(d)(2)(iii); 68 Fed. Reg. at 53,244-53,245. For these reasons, and because *Thorton*'s rather strong dictum, on which the Sixth Circuit relied in this case, has been extant for the last two decades, petitioner's suggestion (Pet. 9-10) that the decision below will have "significant ramifications" for hospitals in the Sixth Circuit appears to be overstated.

C. The Retroactivity Issue Does Not Independently Warrant This Court's Review

The court of appeals also held, in the alternative, that it would not defer to HHS's 2003 regulation because it was promulgated after the conduct at issue in this case and is impermissibly retroactive. Pet. App. 19a-20a. As petitioner explains (Pet. 21-22), the court of appeals' ruling on the retroactivity issue is in error and is contrary to this Court's decision in *Smiley* v. *Citibank (S.D.), N.A.*, 517 U.S. 735, 744 n.3 (1996). In *Smiley*, the Court explained that, "[w]here * * * a court is addressing transactions that occurred at a time when there was no clear agency guidance, it would be absurd to ignore the agency's current authoritative pronouncement of what the statute means." *Ibid.* Respondent does not disagree, suggesting only that the 2002 *proposed* rule, which would have applied EMTALA to some inpatients, should be treated as a "prior agency interpretation." Br. in Opp. 12. An agency proposal soliciting comments does not constitute "clear" agency guidance.

In any event, the court of appeals' error should have little impact beyond this case. HHS's regulation was effective November 10, 2003, and there is a two-year statute of limitations on EMTALA claims. See 42 U.S.C. 1395dd(d)(2)(C). Presumably, any timely filed

EMTALA case currently pending in the Sixth Circuit involves conduct that postdated HHS's promulgation of its regulation. Further review of this issue thus is not independently warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

NEAL KUMAR KATYAL
Acting Solicitor General
TONY WEST
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
MELISSA ARBUS SHERRY
Assistant to the Solicitor General
MICHAEL S. RAAB
DANIEL J. LENERZ
Attorneys

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In The
Supreme Court of the United States

PROVIDENCE HOSPITAL AND
MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative
of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

MOTION TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI AND BRIEF OF *AMICUS CURIAE* THE MICHIGAN HEALTH & HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

JON D. VANDER PLOEG (P24727)
Counsel of Record
SMITH HAUGHEY RICE & ROEGGE
250 MONROE AVE., NW - SUITE 200
GRAND RAPIDS, MI 49503-2251
(616) 774-8000

Counsel of Record for Amicus Curiae Michigan Heath & Hospital Association

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Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 37.2(d) of the Rules of the Supreme Court, the Michigan Health & Hospital Association (MHA) moves this Court for leave to file the accompanying Brief *Amicus Curiae* in support of the Petition for Writ of Certiorari submitted by Petitioner, Providence Hospital and Medical Centers, Inc. Respondent has not granted consent, and this motion is therefore necessary.

The Michigan Health & Hospital Association is an association of hospitals, health systems, and other health care providers throughout Michigan that work together with patients, communities, and providers to improve health care for all Michigan citizens by addressing current issues that impact the ability of its members to deliver care. MHA membership includes all of the state's 145 nonprofit community hospitals, from the largest urban teaching and trauma centers to remote federally designated Critical Access Hospitals that have 25 beds or fewer and serve Michigan's most rural communities.

The doors of Michigan's nonprofit hospitals are open to all, regardless of medical condition or ability to pay for care. In 2007, Michigan's nonprofit hospitals provided $2.6 billion in community benefit, inclusive of free services, health education, outreach, charity care, unpaid care, and state and federal underfunding. Recent economic strains have greatly increased the number of uninsured and underinsured patients seeking care in Michigan's community hospitals, while at the same time chronic underfunding and

underpayment for services weakens the ability of hospitals to continue to serve as the health care safety net for all Michigan's residents. Despite these challenges, the Michigan Health & Hospital Association and Michigan's community hospitals are committed to preserving this important mission.

Congress enacted the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), in 1986 to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. EMTALA was passed in response to growing concern over reports that hospital emergency rooms were refusing to treat patients with emergency conditions if those patients did not have medical insurance. See *Bryan v. Rectors & Visitors of the Univ of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), *quoting* H.R. Rep. No. 241, 99th Cong., 1st sess., part 1 at 27 (1985).

Moreover, the rights and obligations established by EMTALA are fully consistent with the mission of the MHA and Michigan's community hospitals—that is, to provide emergency medical care to all based upon medical need, regardless of ability to pay. The burden borne by these medical providers, however, is substantial, and that burden, as shown by discussions within the current national health care debate, is ever-increasing.

The decision of the Sixth Circuit in this case has expanded the responsibilities borne by health care providers under EMTALA beyond the emergency room to now include those individuals who proceed to good faith admissions for inpatient care and treatment.

This represents a substantial expansion of EMTALA obligations, and potential liabilities for EMTALA violations, beyond the Congressional intent to avoid "patient-dumping" at the emergency room. This expansion of EMTALA obligation by the Sixth Circuit is contrary to the Fourth and Ninth Circuits' readings of the statute. It is contrary to the interpretive rules promulgated by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services. Those Circuits and the regulatory agency have all held that EMTALA's stabilization requirement does not apply once an individual who has come to the emergency department has been admitted, in good faith, to the hospital as an inpatient. The Sixth Circuit, by virtue of this case, stands alone in its contrary interpretation of the EMTALA statute. Consequently, Michigan's hospitals have a substantially greater obligation under EMTALA than do health care providers within the other Circuits. Indeed, in all of the Circuits outside of the Sixth, health care providers follow the CMS regulation, which is consistent with the decisions in the Fourth and Ninth Circuits. Only health care providers within the Sixth Circuit are bound by the expanded role of EMTALA as determined by the Court in this case.

When an individual without insurance or other financial means to pay for medical services is admitted, in good faith, for inpatient treatment, that individual will have other protections, aside from EMTALA, to ensure appropriate care and treatment. These other protections could, indeed, result in liability where a health care provider breaches these other duties. But EMTALA creates substantial additional potential penalties and liabilities for hospitals which are claimed to have violated the

requirements of the Act. In other words, this extension of EMTALA greatly expands potential liability and penalty, including potential exclusion from the Medicare program. 42 U.S.C. § 1395dd(d)(1).

Given the implications of this Sixth Circuit decision for the hospitals, health systems, and other health care providers in Michigan, the MHA has a truly significant interest in this case. The Petition filed by Providence Hospital and Medical Centers has great implication for the delivery of quality medical care to the public by all health care providers within the Sixth Circuit.

The MHA submits the attached Brief to explain, further, the importance of the question presented by this case for all of the MHA constituent members. This Court must resolve the conflict between this interpretation of EMTALA by the Sixth Circuit and the contrary interpretation of it by other Circuits and the Centers for Medicare and Medicaid Services through its promulgated rules.

For the above reasons, the Michigan Health & Hospital Association respectfully requests that this Motion for Leave to file the attached Brief, *Amicus Curiae*, be granted.

Respectfully submitted,

JON D. VANDER PLOEG (P24727)
SMITH HAUGHEY RICE & ROEGGE
250 MONROE AVE. NW – SUITE 200
GRAND RAPIDS, MI 49503-2251
(616) 774-8000

Counsel for Amicus Curiae Michigan Health and Hospital Association

QUESTIONS PRESENTED

The Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), requires hospitals to "screen" any individual who "comes to the emergency department" and to "stabilize" an individual who is determined to have an "emergency medical condition." The Fourth and Ninth Circuits have held, and the Centers for Medicare and Medicaid Services ("CMS") by clarifying regulation in 2003 have directed, that the obligation to stabilize does not apply to an individual who is admitted to the hospital in good faith for inpatient care. The Sixth Circuit in this matter has created a direct conflict with other circuits, and has ruled CMS's regulation invalid, by holding that EMTALA's stabilization requirement extends indefinitely to those admitted to a hospital for inpatient care.

The questions presented are:

1. Whether EMTALA's requirement that any individual who comes to a hospital's emergency department with an emergency medical condition be screened and stabilized should be expanded to continue indefinitely, after the individual has been admitted as an inpatient to the hospital for care or treatment?

2. Whether the CMS's regulation clarifying that EMTALA is inapplicable to hospital inpatients, 42 C.F.R. § 489.24(d)(2)(i), is valid, and applies retroactively?

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INTEREST OF AMICUS CURIAE[1]

The Michigan Health & Hospital Association (MHA) is an association of hospitals, health systems, and other healthcare providers throughout Michigan that work together with patients, communities, and providers to improve health care for all Michigan citizens by addressing current issues that impact the ability of its members to deliver care. MHA membership includes all of the state's 145 nonprofit community hospitals, from the largest urban teaching and trauma centers to remote federally designated Critical Access Hospitals that have 25 beds or fewer and serve Michigan's most rural communities.

The doors of Michigan's nonprofit hospitals are open to all, regardless of medical condition or ability to pay for care. MHA's 2008 community benefits survey of Michigan's nonprofit hospitals revealed that, in 2007, those hospitals provided $2.6 billion in community benefit, inclusive of free services, health education, outreach, charity care, unpaid care, and state and federal underfunding. Recent economic

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[1] Counsel of record for Petitioner has waived the right to receive at least 10 days notice of amicus curiae's intention to file this brief and has consented to the filing of it. Counsel for Respondent has been notified of the intention to file and has consented to waiver of their right to receive at least 10 days notice. Petitioner's waiver of the notice period and consent, and Respondent's waiver of the notice period, are being filed concurrently with this motion and brief. Pursuant to Rule 37.6 of the Supreme Court of the United States, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

strains have greatly increased the number of uninsured and underinsured patients seeking care in Michigan's community hospitals, while at the same time chronic underfunding and underpayment for services weakens the ability of hospitals to continue to serve as the health care safety net for all Michigan's residents. Despite these challenges, the Michigan Health & Hospital Association and Michigan's community hospitals are committed to preserving this important mission.

In 1986 Congress enacted the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), which obligates Medicare participating hospitals to provide care to individuals who come to the emergency department, irrespective of coverage by Medicare, ability to pay, length of stay, or medical standards of practice. While the purpose of EMTALA is entirely consistent with the mission of MHA and Michigan's community hospitals, EMTALA creates potential penalties and liabilities for hospitals in addition to those that might flow from the relationships between hospitals and patients independent of EMTALA. In other words, EMTALA creates another level of potential liability for Michigan's community hospitals.

The case now before the Court on the Petition by Providence Hospital interprets EMTALA in such a way that its obligations extend to patients who have been admitted, in good faith, for inpatient care and treatment, beyond the emergency room. This is an expansion of EMTALA responsibility for hospitals within the Sixth Circuit well beyond the responsibilities faced by hospitals in other Circuits. Concomitant with this expansion of EMTALA rights

and obligations for hospitals within the Sixth Circuit, is a substantial increase in the risk of penalty or liability for EMTALA violations.

The current national debate over health care policy spotlights the financial stress on America's health care system and the plight of those struggling to afford the ever-increasing cost of health care. EMTALA ensures that emergency medical care is available to those who are uninsured, underinsured, or otherwise without financial means to pay for the emergency care that they need. The Sixth Circuit's expansion of EMTALA responsibility beyond the emergency room, and to possibly indefinite hospitalization and treatment, compounds the financial stress on Michigan's community hospitals. Consequently, MHA and its constituents have a substantial stake in the outcome of this case.

SUMMARY OF ARGUMENT

Congress enacted EMTALA in 1986 in response to concerns that hospital emergency rooms were refusing to treat patients with emergency conditions if the patients did not have medical insurance. The statute requires Medicare participating hospitals to provide an "appropriate medical screening examination" to any individual who comes to the emergency department, to determine whether an "emergency medical condition" exists. If the patient has such a condition, the hospital must then either provide care to stabilize that condition, or transfer the individual to another medical facility if medically indicated. Thus, the statute requires emergency department admission and treatment to assure "no material deterioration of the [emergency medical] condition." The hospital must

provide these services regardless of the patient's lack of insurance or other inability to pay for the services.

The Fourth and Ninth Circuits, and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services, have all interpreted EMTALA as imposing these obligations on emergency departments. All have held that EMTALA obligations end there and do not continue when the hospital has, in good faith, admitted the individual to the hospital for inpatient treatment. The decisions of those Circuits, and of the CMS resulting in its promulgated regulation, are all correct.

By contrast, the Sixth Circuit has, in this case, held that EMTALA obligations extend indefinitely even to those patients who have been admitted for inpatient care. Consequently, the circumstances in this case involving a patient who was admitted from the emergency room to the hospital for six days of inpatient care, have been held by the Sixth Circuit to support a claim for EMTALA violation—failure to stabilize. The Sixth Circuit's interpretation of the EMTALA statute is not compelled by its language and expands EMTALA rights and obligations well beyond the Congressional intent. Moreover, the decisions of the other Circuits that are directly contrary to this one are correct as a matter of law, and the Sixth Circuit has erred by holding otherwise.

Further, the Sixth Circuit should have honored the well-considered and duly promulgated CMS regulation which is in line with the other Circuits and directly contrary to the Sixth Circuit's decision.

The Sixth Circuit's decision materially and substantially affects Michigan's community hospitals as represented here by the MHA. This decision has significant adverse financial implications for Michigan's community hospitals which are already suffering from the impact of uncompensated care for the uninsured. Michigan's community hospitals and other health care providers within the membership of the MHA have a great need for the Court to grant this Petition.

ARGUMENT

The Sixth Circuit's Expansion of EMTALA Rights and Obligations to Individuals Admitted to the Hospital for Inpatient Treatment is a Matter of Great Concern to Michigan's Community Hospitals and Merits Review by this Court.

Judge Richard Griffin's dissent in this case states, succinctly, why this Court must grant the Petition and review the majority's decision. Judge Griffin criticizes the majority for following the earlier suggestion in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), that a hospital's EMTALA obligations do not end at the emergency room, but that they continue with application to individuals who are afforded inpatient treatment. As a consequence of this decision, those obligations, and potential liability and penalty for breach, continue indefinitely. By this decision, EMTALA obligations might continue even though the individual has been admitted for years; for example, in the case of an individual who has presented with psychological conditions.

Other Circuits, the Ninth and the Fourth, have rejected this interpretation of the EMTALA statute, holding that the language of the statute does not compel its application beyond the emergency room to patients admitted to the hospital for inpatient treatment. Judge Griffin's dissent summarizes the most obvious reason why this Court must review and decide this issue:

> By remaining loyal to the errant obiter dictum contained in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the majority has perpetuated a serious conflict between our Circuit and the Ninth Circuit, *Bryant v. Adventist Health Sys.*, 289 F.3d 1162 (9th Cir. 2002), the Fourth Circuit, *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349 (4th Cir. 1996), the Federal Regulations, 42 C.F.R. § 489.24(D)(2)(i), and the vast majority of lower court decisions. See generally *Preston v. Meriter Hosp., Inc.*, 747 N.W.2d 173 (Wisc. Ct. of App. 2008), *petition for review denied*, 749 N.W.2d 662 (Wisc. 2008), and cases cited therein.

Judge Griffin went on to say:

> Our panel decision misconstrues EMTALA, making it a general federal medical malpractice statute, rather than an act limited to emergency room screening and stabilization. *Bryan*, 95 F.3d at 351.

The MHA fully concurs in Judge Griffin's dissenting rationale and the many authorities, including the Fourth and Ninth Circuits, and the

regulations promulgated by the Centers for Medicare and Medicaid Services, all of which are contrary to the majority's decision in this case. There is little more for the MHA to say in support of those arguments. The greater reason for MHA's support of Providence Hospital's Petition is for the Court to know the great importance of the issue for the MHA and its constituents.

The MHA does not question here, at all, the wisdom or ethical imperative for the EMTALA legislation. In fact, the purpose for which EMTALA was adopted by Congress is fully consistent with the mission of MHA and its constituent groups—to serve as the health care safety net for all of Michigan's residents.

But there is great cost associated with these obligations, and it is borne by Michigan's hospitals and the health care system in general. The MHA's community benefits survey of Michigan's nonprofit hospitals in 2008 found that they offered $2.6 billion in community benefit in 2007. Although that number includes health education and outreach, it also includes free services, charity care, and unpaid care.

Those who have studied EMTALA in operation over the last two decades have universally noted the stresses that it has placed on the health care system, both in terms of dollars and in terms of the manpower and hospital capacity. Individuals are coming to emergency departments in ever-increasing numbers, without medical insurance or other financial means to

pay. According to the American College of Emergency Physicians[2]:

> Hospitals and physicians shoulder the financial burden for the uninsured by incurring billions of dollars in bad debt or "uncompensated care" each year. Fifty-five percent of emergency care goes uncompensated, according to the Centers for Medicare and Medicaid Services. The amount of uncompensated care delivered by nonfederal community hospitals grew from $6.1 billion in 1983 to $40.7 billion in 2004, according to a 2004 report from the Kaiser Commission on Medicaid and the Uninsured.
>
> In the past, hospitals shifted uncompensated care costs to insured patients to make up the difference. However, cost shifting no longer is a viable option because managed care and other health plans have instituted strict price controls, leaving little margin to shift costs. More than one-third of emergency physicians lose an average of $138,300 each year from EMTALA-related bad debt, according to a May 2003 American Medical Association study. Emergency physicians and other specialists combined lost $4.2 billion in revenue in 2001 providing care mandated by EMTALA.
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> With projections that health care costs will double and the number of uninsured will increase to $53 million by the year 2007, the

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[2] The Uninsured: Access to Medical Care, available at *www.acep.org/patients.aspx?id=25932.*

> nation is faced with how it will continue to provide care for all Americans, not just the disadvantaged. Emergency departments provide an essential community service, similar to fire departments, police departments, and public utilities. The nation cannot afford to allow the emergency care system to collapse because of a lack of funding. It is too high a price to pay in terms of public health effects and human suffering.

Several years ago Congress appropriated some money to address uncompensated care. It appropriated $1 billion over fiscal years 2005-2008 to reimburse hospitals for medical care provided to undocumented aliens. Two-thirds of the appropriated money is allotted to the states based upon the number of undocumented aliens in each state. The remaining one-third is allotted to the six states with the highest numbers of apprehended undocumented aliens. P.L. 108-173, Title X, Subtitle B, § 1011, 117 stat. 2432 (2003). The money available to hospitals through this appropriation is a very small portion of the unfunded cost of EMTALA-related emergency care.

In this case, the Sixth Circuit has interpreted EMTALA erroneously resulting in an expansion of EMTALA rights and obligations with the attendant expansion of potential liability and penalty for hospitals alleged to violate the EMTALA requirements. In other words, the result of the Sixth Circuit's decision is additional financial stress on Michigan's community hospitals. They are already struggling with the financial and facilities costs of providing EMTALA-mandated care.

Individuals who are admitted to hospitals for inpatient treatment already have, without regard to EMTALA, various safeguards to ensure proper care. Hospitals and other health care providers, apart from EMTALA, face potential liability for breaches of those duties associated with those safeguards, with regard to inpatient treatment. If those individuals (admitted inpatients) may also claim statutory damages for EMTALA violations, and where hospitals face the potential of other penalties under EMTALA, then EMTALA is adding significant potential cost for these hospitals and the nation's health care system. This is a matter of grave concern to the MHA and its constituent members. Consequently, the MHA asks that this Court recognize the great importance of this issue for the MHA, its constituents, and the health care system in general, and that the Court grant the Providence Hospital's Petition.

The current national health care debate has focused the attention of all, politicians and the public alike, on questions regarding health care in the face of ever escalating costs, the plight of those who are either unable to find or afford health care insurance, and financial and facility stresses on the nation's health care system which result from underfunding. The Sixth Circuit's expansion of potential EMTALA liability in this case, as it will apply to hospitals throughout the Sixth Circuit, is significant with regard to all of these concerns. Consequently, the MHA respectfully submits that this case is a very significant one for this Court's attention, and that the Petition should be granted.

CONCLUSION

This Court should grant the Petition for Writ of Certiorari.

The Michigan Health & Hospital Association urges this Court to grant the Petition for Writ of Certiorari to review the very important issue of the scope of the EMTALA statute, to give proper effect to the intent of Congress. The Sixth Circuit Court of Appeals, in its majority decision, has erroneously applied EMTALA rights and obligations well beyond the language and intent of Congress, thereby creating additional financial and facilities stress on Michigan's community hospitals.

Respectfully submitted,

JON D. VANDER PLOEG (P24727)
SMITH HAUGHEY RICE & ROEGGE
250 MONROE AVE. NW – SUITE 200
GRAND RAPIDS, MI 49503-2251
(616) 774-8000

Counsel for Amicus Curiae Michigan Health & Hospital Association